

ENQUIRY ON

MENTAL COMPETENCY

FINAL REPORT

CHAIRMAN

PROFESSOR

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1990

ENQUIRY ON MENTAL COMPETENCY
Enquête sur la capacité mentale
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September 18, 1990

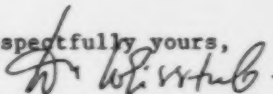
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Dear Madame Minister,

I am pleased to submit my report on Mental Competency. The deliberations of the Advisory Committee were helpful in articulating the criteria and standards for competency. In addition, the many organizations and individuals who submitted briefs proved of great assistance.

I want to thank you for the special opportunity to review this important area of legal-medicine, and I look forward to meeting with you to discuss the recommendations contained in the report.

Respectfully yours,



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EXECUTIVE SUMMARY

Mental competency is a prerequisite for the making of valid decisions in everyday life. Its presence is of particular importance in the health care field where physical as well as mental illnesses may affect an individual's ability to make decisions. The absence of capacity serves as the basis on which the individual will be deprived of the power to make decisions with respect to treatment, financial matters, the appointment of a substitute, and the disclosure of his or her clinical record. This determination is not, however, one that can be made on purely "scientific" grounds. The integration of individual autonomy, best interests and community concerns must reflect the socio-legal and cultural context in which it is being performed. Since there is no objective specification of how these are to be integrated, it is necessary that we structure the testing of decision making capacity to reflect significant, sound values while at the same time protecting legal principles that are enshrined in our liberal democratic system.

Although this integration clearly favours individual autonomy and, therefore, requires that presumptions, burdens, etc. favour the protection of individual rights, clear evidence of functional incapacity will rebut the presumptions and invite an intervention to protect the best interests of the individual. The entire testing process must reflect the autonomy and best interests principles, while conforming to social needs for fairness, equity and administrative simplicity.

The principle of individual autonomy requires that we endeavour to respect the wishes of individuals to the full extent of their decisional capacity. The most difficult issues in the assessment of capacity involve individuals who appear capable of making some decisions but not others. Individuals who are completely (globally) incompetent do not for the most part pose assessment problems. It is therefore the determination of the "marginal" capacity possessed by individuals whose abilities, while somewhat impaired, are sufficient to allow them to form and express a preference regarding a specific issue that is the task that has been addressed by this Enquiry. The desirability of allowing individuals to exercise the greatest possible measure of control over their bodies and their lives demands that tests of decisional capacity accurately reflect the functional requirements of a particular decision. This in turn requires that such parameters be clearly identified and assessed in an appropriate manner.

In addition to the functional requirements of the decisions, it is necessary to be sensitive to those who will be impacted upon by the assessment of capacity. Striking an appropriate balance between the desire to protect substantive interests and the need to provide workable procedures is one of the major tasks that has been faced by the Enquiry in this respect.

Testing of decisional capacity can be used to further a number of different objectives. The present practice employs testing primarily in those cases where the individual and another party (often a doctor in the medical context) disagree. This practice has however been questioned by patient rights groups and other concerned parties. The alternative of using a broader set of conditions to justify testing would result in a greater number of assessments and would implicitly be using the assessment process as a method of reviewing the quality of the informally made substituted decisions in many cases. The present approach can be defended on the basis that it respects the choice made by the individual and avoids the stigmatizing of individuals with the label of incompetency when in fact the individual has made a choice to informally delegate the decision to a trusted care giver. Conceptually this approach is consistent with the belief that the uncertainty with respect to incapacity is greater than that with respect to desirability of the outcome. The use, on the other hand, of decisional capacity testing in all doubtful cases allows an official substitute decision process to be employed as a way of reviewing the correctness of the recommended decision.

The principle to be favoured in the assessment of capacity is that of furthering individuals' autonomy. For this reason, and in light of the uncertainty associated with the determination of capacity, we generally favour restricting assessments to those individuals whose behaviour has given rise to a strong suspicion of incapacity. However, in situations where the individual may be susceptible to institutional coercion, we favour a more comprehensive testing of capacity so as to protect incapable consenters.

The basis of capacity assessment must be the measurement of functional abilities of the individual and although it may prove desirable to allow some status or outcome considerations to be employed in the assessment process, such practices must reflect either improved means of functional evaluation or else a clearly enunciated policy decision.

In this report, the burden of proof lies on the party asserting incapacity, and the standard of proof is on a balance of probabilities. Other procedural concerns including the choice of the assessor, the form of notice to the individual, the provision of rights advice and counsel, the maximum period between reviews and the availability of appeal options depend on the context in which the assessment is taking place.

It would appear that the best approach to assessment involves the testing of the individual in the decisional context. While in the future, it may become possible to more accurately quantify the parameters of decisional capacity in a way that would allow the individual and the context to be assessed separately; the report has taken the view that it is not possible to achieve this goal at the present time.

Limitations with respect to the scope of the capacity assessment must be defined in terms of both subject matter and time. In order to make marginal capacity a meaningful concept, it is necessary to consciously limit the scope of the validity of a determination of capacity in terms of the subject matter to which the determination would apply. Mandatory annual review in the case of chronic conditions, and after three months for acute conditions are the recommended maximums, with the provision for earlier reviews at the request of either a care giver or the decision maker.

The report summarizes the factors which are to be weighed when assessing the capacity of the individual. The primary factors are those related to the functional abilities of the individual; other evidence pertaining to the individual, including that of changing decisional practices and clinical diagnoses must at most be accorded secondary importance. The use of situational parameters depends very much on the nature of the decision for which the assessment is being made and will vary from context to context. In general, however, increasing complexity and importance of the decision will increase the requirement for capacity. Decreasing importance and increasing uncertainty with respect to outcome serve to reduce the requirements, and below a certain *de minimus* level, should allow the individual's wishes to prevail unchallenged.

A testing protocol has been developed to facilitate the assessment of capacity in an effective and efficient manner. The protocol involves up to four stages of assessment: a threshold for determining that an assessment is necessary; a simple screening test to detect problems with capacity; a formal assessment which provides a thorough review of all relevant parameters; and the right to appeal to the review board, with the possibility of a further appeal to district court.

Formal assessment of capacity should take into account the vulnerabilities and special characteristics of the individual and must as well be performed in a manner that is responsive to both cultural and social concerns. When making determinations based on research that has been conducted in this field, it is necessary that both the methodology and underlying ideology of research be

critically examined, especially the extent to which they influence the content, arrangement and interpretation of data.

The statutory provisions and court decisions relevant to the assessment of competency highlight many of the issues and tensions that underlie the specification of criteria for the testing of capacity. The most fundamental conflict is obviously that between the promotion of autonomy as against the best interests of the individual. Notable in this regard is the extent to which the courts have been ready to intervene to prevent the occurrence of what they determine to be an undesirable outcome. The balance between the consideration of the process by which a decision is made, as opposed to the probable outcome, seems to have been struck by judges in light of all the circumstances of each case and has demonstrated the common law's tendency to favour a "reasonableness" based approach. In a number of the common law decisions, the interpretation of the requirements for "understanding" and "appreciation" appear to be informed by the context, and are set higher with respect to decisions that may be tainted with concerns about undue influence or other such factors than in the absence of such concerns.

In conclusion, it is apparent that the common law has not been able to resolve, with any measure of clarity, the underlying conflicts, in particular the weight to be given the evidence of the process as against that of the outcome. The courts have generally seemed unwilling to recognize as valid any decision that they perceived as clearly unreasonable; and may therefore be seen as requiring that the decision maker conform with a socially informed view of reality. The "delusional" individual presents the most intractable dilemma to an assessor of capacity insofar as the individual's alleged incapacity arises out of his or her refusal or inability to perceive the world in the socially agreed fashion. For this reason we propose that this category of individual be accorded special recognition and procedural safeguards so as to ensure that the assessment of competency is not employed to enforce social conformity.

The following section summarizes the recommendations of the Enquiry with respect to the determination of mental capacity in the health care field and closely related areas. These recommendations identify general principles, a proposed assessment protocol and tests of capacity, suggestions for legislative change, and topics for additional study.

RECOMMENDATIONS

These recommendations are to be interpreted in accordance with the principles and interests that were identified in the Executive Summary and the body of the report. These principles require that the autonomy and rights of an individual, as set out in the law, including the *Canadian Charter of Rights and Freedoms*, be accorded priority and that clear evidence of functional incapacity be adduced before the preferences of the individual be overridden by a substitute. However, in addition to protecting the autonomy of competent individuals the law must also promote the welfare and best interests of those who are determined to be incapable.

The rapidly evolving state of the art with respect to the instruments, techniques and technologies which may be employed in the assessment of capacity precludes us from making specific recommendations with respect to these elements. What can and will be recommended are a protocol, tests, and some guiding principles to be implemented using the best available instruments, tools and technologies.

We propose that pilot or demonstration studies be supported to identify the most effective and efficient methods for implementing the following recommendations. Proposals for studies that highlight the two important dimensions of operationalizing these recommendations -- selection of personnel, training and procedures,¹ and the selection of specific test instruments² -- should be solicited. These pilot studies should be conducted in a variety of settings such as, psychiatric and general hospitals, geriatric and children's facilities, and community health centres. When evaluating models for implementation of these recommendations, it will be necessary to consider the relationship between capacity and support structures, both institutional and non-institutional, in the community. These support structures can be used to effectively enhance the capacity of individuals to make important decisions and therefore will influence the value of these models. In addition, although effectiveness and efficiency are parameters to be evaluated, it is important to recognize that the legal and ethical requirements for individual autonomy and self-determination predominate and therefore must be

¹ Among the elements that should be assessed are: the amount of time required to complete each stage; staff workload; effectiveness (i.e., ease of entry into the process, moving between stages; completing process, etc.); number of formal assessments completed; number of findings of incapacity; and portability.

² Among the parameters that need to be assessed are: reliability and validity (across raters and overtime); usefulness; improved patient/resident outcome; degree of professional judgment and discretion exercised; and relevancy.

respected. At present since the legal requirements of informed consent prescribe that the above principles be observed and respected, the scope of the obligations set out below are not dramatically different from those presently in force in many situations, although more personnel may be required in some institutions such as nursing homes.

GENERAL RECOMMENDATIONS

- 1) **Presumption of Capacity** - Individuals should be presumed to be capable to make any specific decision. (See Chapters I, II and VIII)
- 2) **Standard of Proof** - The presumption that the individual has the decisional capacity to make a specific decision should prevail unless there is clear evidence, on a balance of probabilities, of incapacity to make that decision. (See Chapters I, VI and VIII)
- 3) **Burden of Proof** - The onus of demonstrating incapacity rests on the party alleging the incapacity. (See Chapter VIII)
- 4) **Marginal Competency** - Competency is not to be considered a global characteristic but a marginal one. The use of the word "marginal" emphasizes that competency must be understood and evaluated in terms of specific situations or types of decision. We recommend that the term "decisional capacity" be used to designate the marginal competency to make a specified decision; therefore, determinations of capacity should be restricted to the assessment of the decisional capacity to make a specific decision, or type of decision. (See Chapters I, II, III and X)
- 5) **Scope of Determination - Time Limits** - Capacity may vary or fluctuate over time. The validity of any one determination of decisional incapacity should therefore be limited to the period during which, on clinical assessment, no significant change in capacity is likely to occur. With the exception of a chronic and probably irreversible condition, the determination should not be valid beyond three months. In the case of individuals whose incapacity is attributable to a chronic condition, in which significant change is unlikely, the maximum period between assessments should be twelve months. However, in any case when either the caregiver or decision maker requests a review it should be provided. In the event that the individual's capacity is found to fluctuate significantly over time, the assessment should take place as closely as possible to when the decision is to be made. (See Chapters II, III and X)

- 6) **Functional Basis of Assessment** - The assessment of an individual's decisional capacity must reflect the specific functional requirements of that particular decision. It is not therefore to be based solely on the assessment of the individual's abilities in the abstract, the status of the individual or the probable outcome of the individual's choice. (See Chapters II and X)
- 7) **Capacity to Consent to Assessment** - To overcome the conundrum posed by uncertainty with respect to individuals' capacity to consent to a competency assessment, individuals should be deemed capable to consent to assessments, including psychological or medical examinations, which are non-invasive and pose no significant risk to the individual. (See Chapter II)
- 8) **Assessing an Uncooperative Decision Maker** - The persistent refusal of an individual to cooperate in an assessment of his or her capacity would require that the formal assessment be made without this input. The assessor would collect as much information as possible and if this data indicated that the individual is incapable, then this information would be forwarded to the Review Board for a final determination. Where possible the collection of such information should be conducted with the consent of the decision maker, and in any event care should be taken that the confidentiality rights of the decision maker be respected. The decision maker would be afforded the usual procedural rights before the Review Board, including standing and representation, and he or she would be bound by the result. (See Chapters II and XIII)
- 9) **Capacity to Retain and Instruct Counsel** - A person whose capacity is at issue should be presumed to have the capacity to retain and instruct counsel to act on his or her behalf at all stages of capacity assessment. This presumption is however limited to proceedings brought to determine capacity.³ Counsel would however be obligated to act in conformity with the applicable professional principles and guidelines that now exist and those which will be developed to govern the conduct of advocacy on behalf of incapable or doubtfully capable individuals. (See Chapters I, V, XV, and XVI)
- 10) **General Competency Review Board** - A review board should be established to adjudicate disputes with respect to capacity determinations. This function could

³ See recommendation for further study on the subject of criteria for determining an individual's capacity to instruct counsel.

be achieved by the expansion of the jurisdiction of the existing *Mental Health Act* Review Boards or through the creation of a separate administrative body. Since the existing *Mental Health Act* Review Boards have acquired expertise in competency matters it would seem preferable that the functions of this Board be expanded to include the resolution of the competency disputes of all individuals in provincial facilities. The words "Review Board" as used in this report refer to either an expanded version of the present *Mental Health Act* Review Board or to a new body which we assume will exercise similar powers under similar procedures. (See Chapters II and XV)

- 11) **Uniformity in Capacity Assessment** - The anomalies in the different statutes which deal with the assessment of capacity, and the care and management of those of dubious capacity should be eliminated. Furthermore, the rules applicable to minors, the powers of patient's representatives, selection of substitutes, etc. should be made uniform throughout all areas of the health care system in Ontario. Our recommendations in this regard should be considered as a basis for changes in other areas under provincial jurisdiction. (See Chapter XVI)
- 12) **Training Professionals for the Detection of Incapacity** - Professionals, such as lawyers, accountants, and all others who rely on clients to give them capable instruction, should be trained to identify individuals who may incapable, and also instructed with respect to the legal implications of possible incapacity, including the duty of the professional to have the individual properly assessed to resolve doubt in this regard. Such training should be included in the initial education of such professionals and made the subject of continuing education programs. (See Chapters II, and XV)
- 13) **Training of Assessors** - Educational materials and training curricula should be developed to train clinicians, para-medical personnel and others to perform and interpret the screening test. Protocols for a formal assessment should be developed, and training programs for those clinicians who have not been psychiatrically trained instituted where necessary. (See Chapters II and XV)
- 14) **Assessment Reimbursement Procedure** - The assessment of an individual's capacity should be recognized as a necessary and therefore reimbursable procedure within the health care system. (See Chapter II)
- 15) **Restrictions on Choice of Substitute Decision Maker** - Except under formal legal supervision, under no other circumstances should a caregiver, advocate or

administrator be appointed as a substitute decision maker. (See Chapters V and X)

- 16) **System for the Appointment of Substitute Decision Makers** - Although the appointment of substitute decision makers falls outside the mandate of the Enquiry (this being the subject of the *Fram Report*) it is impossible to completely divorce the finding of incapacity from the consequences of this finding. It would therefore not appear to be practicable to implement the recommendations of this report in the absence of a comprehensive and functional system for the appointment and regulation of substitute decision makers. (See Chapters VI and X)
- 17) **Guidelines for the Instruction of Counsel** - The representation of doubtfully capable and incapable individuals including non-instructed representation was considered in the *Manson*⁴ and *O'Sullivan*⁵ reports. We support the development of guidelines to help clarify the duties of counsels and advocates when acting on behalf of such individuals, and in particular to help resolve the difficulties now encountered when a counsel is uncertain of the capacity of either their client or another party with whom they are dealing on behalf of their client. (See Chapters I and V)

RECOMMENDED ASSESSMENT PROTOCOL

- 18) **Recommended Assessment Protocol** - A four stage approach to the assessment of capacity should be employed. The four stages are as follows: the threshold test, screening test, formal assessment, and appeal to the review board and court. (See Chapter XV)
- 19) **Threshold Test** - The threshold test is a preliminary determination that the individual's capacity is in doubt and therefore that the individual should be administered the screening test. This determination would normally be made by a professional in a fiduciary relationship to the decision maker and would result from doubt being raised about the decision maker's mental capacity. Alternatively, in order to protect the autonomy of individuals who would accept treatment while incapable, the involuntary admission of the individual to a

⁴ A. Manson, *Chairperson Advocacy in Psychiatric Hospitals: Evaluation of the Psychiatric Patient Advocate Office* (Toronto: Ministry of Health, 1987).

⁵ S. O'Sullivan, *Chairman You've Got A Friend - A Review of Advocacy in Ontario: Report of the Review of Advocacy for Vulnerable Adults* (Toronto: Ministry of the Attorney General, 1987).

psychiatric facility or their admission (for a protracted period) to a chronic care facility would be deemed to satisfy the requirements of the threshold test and should require that such individuals be administered the screening test. We note that in some situations capacity testing would need to be performed prior to admission in order to ensure that the individual was capable of giving a valid consent to admission. (See Chapter XV)

- 20) **Screening Test** - The screening test would be administered by a lay or professional person trained to perform this task. The recommended screening test includes elements from the Folstein Mini Mental State Exam and questions intended to reflect the specific requirements of the particular decision. The recommended test is as follows:⁶

Orientation

- 1) Do you know who you are? Tell us your name. (1 point)
- 2) Do you know where you are? (Country, Province, Town, Address) (4 points)
- 3) Do you know what season, month and year it is? (3 points)

Registration and Short Term Memory

- 4) Name three objects, one second between each. Then ask the person to repeat the three objects after you have said them. (3 Points) Repeat the process until the individual has learnt all three, to a maximum of six times.

Attention and Calculation

- 5) Have the individual count down by 7s from a number that is close to 100, if he or she is unable, ask him or her to alternatively spell "world" backwards. (5 points)

Recall

- 6) Have the individual repeat the three objects again. (3 points)

⁶ Please see the discussion of the screening test in the body of the report for further information on the applicable pass/fail scores and the limitations of this test.

Language

- 7) Repeat the following: "No Ifs, Ands or Buts". (1 point)
- 8) Read and obey the following: "Close your eyes". (2 points)
- 9) Write a sentence. (1 point)

Understanding

The decision maker must be informed of the nature of the decision, the choices that are available and the advantages and disadvantages of these choices.

- 10) What is the decision you are being asked to make? (1 point)
- 11) Why do you have to make this decision, and what choices do you have? (2 points)
- 12) Can you tell me the advantages and disadvantages of each choice? (4 points)

The assessment should focus on the individual's "functional" rather than "formal" abilities and in this way reflect his or her ability to operate, notwithstanding his or her limitations, rather than limitations in the abstract. (See the instructions in the body of the report). We recommend that 18/19 out of 23 be used as the cut-off for the first 9 questions and the use of a reduced 15/16 out of 23 cut-off requirement for individuals with less than a high school education. We recommend that 4/5 out of 7 be used as the cut-off for the remaining three questions dealing with the understanding of the decision. A failure on either part of the screening test would require that the individual undergo a formal assessment. If an individual passes the screening test, he or she is to be considered capable and would not be formally assessed unless the party alleging incapacity was able to produce cogent, *prima facie* evidence of incapacity and thereby justify overriding the results of the screening test. (See Chapter XV)

- 21) **Formal Assessment** - The first stage of the formal assessment is a test for "significant impact". The assessment of "significant impact" is made by the assessor and based upon an objective reasonableness standard. If it is determined that the decision involves no significant impact the assessment will

be ended and the individual's wishes will prevail in those cases where the individual can express a clear choice. If the contrary is found, the remainder of the assessment will proceed.

We recommend that the formal assessment:

- 1) take the form of a new assessment, rather than a review of the screening test;
- 2) trigger the notification of rights advice and/or a patient advocate in contexts in which such are available, and the notification of the individual that he or she can contact counsel or some other trusted person;
- 3) inform the decision maker that a determination of incapacity is reviewable by the Review Board and that a second screening test may also be requested; and
- 4) result in a report that would be appended to the medical record.

This assessment would be performed by psychiatrists, non-psychiatric physicians, and psychologists⁷ who would not have performed the screening in the instant case, and who will have been trained to perform this task in addition to their usual professional training. When performing this assessment, the assessor should focus on individuals' "functional" rather than abstract or "formal" abilities and in this way assess ability to operate, notwithstanding limitations. While the evolving state of the art with respect to the testing of capacity makes it both impractical and undesirable for us to attempt to definitively set out the instruments, tests and procedures that should be applied, we note that the assessment should consider:

relevant medical history;

appropriate medical evaluation (physical exam including diagnostic tests);

presumed etiology;

course and severity of the condition causing the impairment;

appearance and affect;

mood;

⁷ Duly qualified (with appropriate clinical training) and registered under the *Psychologists Registration Act*, R.S.O. 1980, c.404.

behaviour (information should be derived not only from the clinical history but also from the observations of friends, family members, etc.).

intelligence (especially abstract ability, reasoning, insight and judgment);

memory (for recent and remote events);

sensorium (consciousness and orientation);

thought content (suspiciousness, paranoid ideation, delusions, etc.);

thought process (volume and flow of thought, logic, coherence, etc.);

language ability (ability to understand through writing or speech and to express oneself orally or in writing);

awareness of current health status and/or financial status;

learning (See Chapter XV)

- 22) **Review Board and the Courts** - The Review Board and the Courts serve three related roles. Firstly, a form of review for capacity determinations which are susceptible to the unconstrained exercise of discretion. Secondly, to ensure that all persons found to be incapable would have access to a "fair hearing" at which this determination could be challenged. Thirdly, in their appellate role, the review boards and courts should provide an authoritative review of the implementation of professionally accepted standards and procedures, and assist in the interpretation of the applicable statutory provisions. (See Chapters II and XV)

Factors to be Considered During Capacity Assessment

- 23) **Communication** - The individual's ability and desire to communicate with the assessor is a necessary precondition for the effective testing of capacity. Efforts must be made to identify and redress any communication difficulties, including those arising out of linguistic, social or cultural differences between the decision maker and assessor, as well as any psychological, medical or other impediments. (See Chapters X and XIV)
- 24) **Adequacy and Presentation of Information** - The presentation of essential information in a neutral and effective manner is a fundamental requirement for a capable decision and has a significant impact on the apparent decisional capacity of the decision maker. Research has demonstrated the efficacy of careful, repeated presentation of information with testing and feedback to ensure comprehension. In order to avoid biasing the decision maker, information should be presented neutrally in terms of the probability of success and the probability of failure. The language of the information should be at a level that can easily be comprehended by the decision maker. (See Chapter X)

- 25) **Voluntariness** - The impact of coercive influences on the apparent capacity of the individual requires that care be taken to ensure that vulnerable individuals are made aware that they may freely choose between the available options and that they should not feel constrained by the recommendation of an authority figure. (See Chapter X)
- 26) **Overcoming Expectations and Creating a Record** - Formal assessment should be structured to reduce subjectivity and should result in a comprehensive record of the individual's performance with respect to different parameters. These requirements are necessary to overcome the tendency of an assessor's expectations to colour his or her assessment and should, in addition, improve the quality of the assessment and serve to reduce the incidence of review. (See Chapter X)
- 27) **Diagnoses** - While noting that the correlation between the extent of organic or other medically measurable defects and loss of functionality is not high, the existence of an objectively corroborated physical diagnosis that helps to explain unambiguously pathological behaviour should be taken into account. (See Chapters X and XIII)
- 28) **Delusions and Procedural Safeguards** - Delusions should be considered only if they materially affect the individual's ability to make the decision in question. The assessor may use the delusion as determinative of a finding of incapacity only if:
- 1) this determination is communicated to a Patient Advocate or other third party representing the decision maker;
 - 2) the representative is fully aware of and informs the decision maker of his or her right to appeal the finding of incapacity to the Review Board; and
 - 3) the decision maker and his or her representative are both informed that the diagnoses of a delusion formed the basis of a determination of incapacity. (See Chapters X, XIV and XV)
- 29) **Frontal Lobe Disturbances** - The assessor should endeavour to rule out the possibility of a frontal lobe disturbance by a careful inquiry into the health status of the individual, i.e., looking for signals such as a recent trauma, alcoholism, encephalitis, etc. When such indicators exist, the assessor should

carefully assess the individual's ability to organize and understand complex information using specific psychological tests. (See Chapter XV)

- 30) **Changes in Behaviour** - A substantial and unexplained change in an individual's behaviour that helps to corroborate the impact of a diagnosed condition, or conversely, the absence of a change in personality or decisional patterns, despite the diagnosis of a medical condition, may be considered in an assessment of capacity. (See Chapters X and XIV)
- 31) **Use of Sliding Scales** - The complexity of the information that would normally be considered in the making of a decision, the nature and complexity of alternative choices, the importance of the decision to the decision maker, the certainty of the outcomes and the manner in which the decision will be made by a substitute are all factors which will affect the basis on which the determination of decisional capacity should be made. Increasing complexity, importance, and certainty serve to increase the level of requisite capacity. Although the issues raised by the selection of a substitute fall outside the scope of this report, the manner of the appointment and safeguards associated with the regulation of substitutes is a factor that may influence the assessment of the individual's capacity. (See Chapters II, VI and X)
- 32) **Relevance not Reasonableness** - The requirement of understanding and appreciation that forms the basis of the recommended test of mental capacity should not be interpreted as requiring that the decision maker be able to provide "rational" or "recognizable" reasons. Insofar as it is necessary that reasons be given, the test should require the assessor demonstrate that the reasons given for the decision are not "relevant". Relevance is preferred over reasonableness because relevance can be objectively determined whereas reasonableness provides the opportunity for the projection of the assessor's values and preferences onto the decision. (See Chapters I and X)
- 33) **Reasonableness - Safeguards** - Should policy require the use of a "reasonableness" standard, the following conditions should be met to provide safeguards to minimize the potential abuse of this approach:
 - 1) the determination would have to be communicated to a Patient Advocate or another individual representing the decision maker;

- 2) the representative would have to be fully aware of and inform the decision maker of his or her right to appeal the finding of incapacity to the Review Board; and
 - 3) the decision maker and his or her representative would have to be informed that unreasonableness formed the basis of the determination of incapacity.
- 34) **Changing Decisional Practices** - Evidence of socially unacceptable behaviour should not *per se* be considered a dominant factor during capacity assessment. However, unexplained changes in the manner in which an individual makes decisions may reflect changes in the individual's decision making capacity and should be considered on this basis. (See Chapter X)

RECOMMENDED CRITERIA FOR TESTS OF CAPACITY

- 35) **Capacity to Make a Treatment Decision** - In order to be considered mentally capable to make a treatment decision, an individual must have the ability:
- a) to understand the nature of the condition for which the treatment is proposed;
 - b) to understand the nature of the proposed treatment; and
 - c) to appreciate the consequences of giving or withholding consent. (See Chapters X and XVI)
- 36) **Capacity to Make a Financial Decision** - In order to be considered mentally capable to make a financial decision, an individual must have the ability:
- a) to understand the nature of the financial decision and the choices available to him or her;
 - b) to understand his or her relationship to the parties to and/or potential beneficiaries of the transaction or transactions which give rise to the decision; and
 - c) to appreciate the consequences of making the decision. (See Chapters X and XVI)

37) **Capacity to Select a Substitute Decision Maker** - In order to be considered mentally capable to appoint a substitute decision maker, an individual must have the ability:

- a) to understand the nature of the appointment and the duties of the substitute decision maker;
- b) to understand his or her relationship to the proposed substitute; and
- c) to appreciate the consequences of appointing the substitute decision maker. (See Chapters X and XVI)

38) **Capacity to Review Clinical Record** - Individuals should be deemed capable to review, but not copy, their clinical records unless it can be shown that serious harm is likely to result. (See Chapters X and XVI)

39) **Capacity to Disclose Clinical Record** - In order to be considered mentally capable to make decisions concerning the disclosure of his or her clinical record, an individual must have the ability:

- a) to understand the nature of the record and the reason that disclosure is being requested;
- b) to understand his or her relationship to the parties who are to be given access to the record; and
- c) to appreciate the consequences of the disclosure of the record. (See Chapters X and XVI)

Assessing Capacity in Minors and the Geriatric Population

40) **Minors Age 14 and Older Treated as Adult** - Young persons age 14 or above should be treated as adults with respect to their decisional prerogatives and should be assessed as adults with respect to their decisional capacity. (See Chapter XII)

41) **Minors Under 14 Presumed Incapable** - Young persons under the age of 14 are rebuttably presumed decisionally incapable. However, because it is recognized that some individual's in this group are in fact capable, the wishes of individual's in this category should not, and may not, be overridden unless and until they

have been formally assessed and their incapacity established. The following three scenarios illustrate this principle in operation:

- a) In most cases both the young person and parent(s) or guardian will agree on a decision and it will not be necessary to assess the young person's capacity.
 - b) In situations in which a young person wishes to make a decision without the involvement of a parent(s) or guardian, a formal assessment must be made to determine whether the young person is capable. If found capable the young person's decision must be respected, if determined to be incapable this decision may not be made without the authorization of the young person's parent(s) or guardian.
 - c) Similarly in those situations when the young person and parent(s) or guardian disagree, a formal assessment must be made to determine whether the young person is capable. If found capable the young person's decision must be respected. If determined to be incapable the choice of the young person's parent or guardian (subject to applicable legal constraints) will prevail. (See Chapter XII)
- 42) **Functional Testing of the Geriatric Population** - Self functioning is an especially important parameter to consider when assessing the capacity of the geriatric population. Assessments should be careful to distinguish between physical and mental limitations, and not imply mental incapacity from physical infirmity. (See Chapter XII)
- 43) **Cognitive Testing in the Geriatric Population** - Cognitive parameters, as determined by existing tests, are not generally standardized for the geriatric population and should therefore be less heavily weighted when assessing the decisional capacity of the geriatric population. (See Chapter XII)
- 44) **Recognition of Established Life Preferences** - Established life preferences are the patterns of behaviour and choices that are developed and expressed by the member of the geriatric population over time. Life choices made in accordance with such preferences should be respected in the absence of serious cognitive or functional deficits. (See Chapter XII)

LEGISLATIVE RECOMMENDATIONS

- 1) **Presumption of Capacity** - The presumption of capacity, onus on the party alleging incapacity, and the use of the balance of probabilities as the standard of proof, should be codified in relevant statutes. (See Chapters I and VIII)
- 2) **Recognition of Marginal Capacity** - The provisions for the assessment of global competency, such as those in the *Mental Incompetency Act*, should be replaced with provisions giving effect to the assessment of decisional capacity as a parameter that must be assessed on a situational basis. Such assessments should test the individual's ability in terms of the functional requirements of the decision. (See Chapters I, II, III and X)
- 3) **Time Limitation on Assessment** - A determination of incapacity should be limited in duration. The maximum duration of such determinations should be one year for individuals with a chronic condition and three months for all others. (See Chapters II, III and X)
- 4) **Proposed Assessment Protocol** - The four stage approach to the assessment of capacity set out above should be implemented and recognized in all relevant statutes. (See Chapter XV)
- 5) **Proposed Tests of Capacity** - The proposed criteria, set out above, should be employed as the statutory basis for tests of capacity. (See Chapter XV)
- 6) **Capacity to Copy** - The requirements for an individual to copy his or her clinical record could be made the same as that to disclose the record to a third party. (See Chapters X and XVI)
- 7) **Capacity in Minors** - The above recommendations with respect to the assessment of capacity in minors should be incorporated into statutes pertaining to the care of minors. (See Chapter XII)
- 8) **Expansion of the Role of the Review Board** - The role of the review board be broadened to give it jurisdiction to deal with the determination of capacity and related issues that arise with respect to all individuals. (See Chapters II and XV)
- 9) **Uniformity in Capacity Assessment** - The anomalies in the provisions of different statutes, including the *Mental Health Act*, the *Public Hospitals Act* and

the *Mental Incompetency Act*, which deal with the determination and treatment of those of dubious capacity should be eliminated. (See Chapter XVI)

SUBJECTS RECOMMENDED FOR ADDITIONAL STUDY

- 1) **Capacity and Commitment** - A large number of the submissions received by the Enquiry discussed the interface between capacity and commitment, dissatisfaction with the criteria for involuntary committal, and the dilemma posed to caregivers and families by the committed, but capable, patient. Although the subject of committal is clearly outside the mandate of the Enquiry, and will not be discussed herein, the numerous submissions we received on this subject lead us to recommend this topic and its relationship to capacity be given further consideration. (See Chapters I, II, X and XV)
- 2) **Living Wills** - Living wills are a logical extension of the principles promoted by the appointment of substitute decision makers and durable powers of attorneys. The issues raised by the proliferation of options for the technological extension of life require that further study be made of the merits of living wills and the limits that should be imposed on such documents. (See Chapter XII)
- 3) **Expanding the Role of the Provincial Review Boards** - We are concerned that the use of the courts as the primary arbiter of capacity to make financial decisions is too costly and time consuming to allow the effective recognition of the concept of marginal capacity. We, therefore, recommend that some consideration be given to the use of review boards to perform this function. (See Chapters II and XV)
- 4) **Criteria for Capacity to Instruct Counsel** - We recommend the development of criteria for the determination of an individual's capacity to retain and instruct counsel in non-criminal matters. In this regard it must be noted that our recommendation that an individual be presumed capable to retain and instruct counsel applies only to proceedings concerned with the determination of an individual's capacity, and therefore that doubts about an individual's capacity to retain and instruct counsel for any other purpose or proceeding would have to be made the subject of a specific capacity determination. (See Chapters I, V and XV)

- 5) **Modes of Decision Making in Capacity Determination** - We recommend that some study be made of the use of alternative, non-adversarial, proceedings for the review of capacity determinations. It has been suggested that the use a more inquisitorial approach could provide benefits in the form of better fact finding and positive therapeutic effects. (See Chapter II)

BACKGROUND OF THE ENQUIRY

In apparent response to the concerns raised by health care providers, consumers and other interested parties the Minister of Health for Ontario arranged for the creation of the Enquiry on Mental Competency during 1988.⁸ Professor David N. Weisstub was retained to serve as the Chairman to the Enquiry and later in 1988 an Advisory Committee was appointed to assist him in this work.

The following individuals were appointed to the Advisory Committee and have contributed their time and expertise to the work of the Enquiry.

Ms. Lesley May Bell	Dr. Thomas McCann
Mr. Brian Davidson	Dr. Anthony McFarthing
Dr. Patricia Defeudis	Ms. Carla McKague
Mr. Terry Dokis	Dr. Guyon Mersereau
Dr. Brian Hoffman	Mr. John Morris
Mr. Oscar Johvicas	Ms. Carla Peppler
Dr. Llewellyn Joseph	Ms. Carolyn Shushelski
Mr. Leonard Marvy	Mr. Rodney Walsh

The Enquiry was given the following terms of reference:

1. To examine the issues involved in developing criteria for determining the mental competence of individuals to make decisions.
2. To consult with and obtain the viewpoints of significant professional, legal, and consumer interest groups, and to liaise with appropriate others, e.g., the Interministry Committee on Guardianship and Advocacy.

⁸ Please see the Appendices to this report for a more detailed discussion of the historical context and developments leading up to the formation of the Enquiry.

3. To develop a Report that includes a recommended set of clinical standards or criteria for determining the mental competence of individuals to make decisions relevant to health care, including but not necessarily limited to the following areas:
 - medical, surgical or psychiatric treatment;
 - access to or disclosure of one's clinical records;
 - appointment of a substitute decision maker;
 - management of one's own financial affairs.
4. To advise the Minister of any legislative implications, if appropriate.
5. To submit a Report and Recommendations to the Minister within nine months of the commencement of the study.

Following the appointment of the Advisory Committee it was decided that the Enquiry would hold a number of meetings at which outside experts would make presentations and discuss controversial issues with the members of the Advisory Committee. The Enquiry sought out submissions from potentially interested parties by mail and through advertisements placed in newspapers in all regions of the province. The Advisory Committee was provided with copies of the bibliography of articles, books, cases, statutes and copies of a number of relevant government reports.

At the subsequent meeting Dr. Paul Appelbaum, A.F. Zeleznik Professor of Psychiatry and Director of the Law and Psychiatry Program, University of Massachusetts Medical Center, a leading researcher in this area, presented a report on his investigations. Subcommittees were constituted to review the historical developments leading up to the present legal and medical definitions of capacity and to analyze the language and concepts relevant to the subject.⁹ A number of decisions were also made with respect to the use of outside expert consultants to report on specific issues and in particular a decision was made to retain Dr. Laurence Tancredi, Director of the Health Law Program and Kraft Eidman Professor at the University of Texas Medical Center at Houston to report on the potential impact of emerging medical technologies on the evaluation of capacity.

⁹ The work of these subcommittees has been incorporated in the body of the report and the Appendices of this report.

At a later meeting Dr. Michel Silberfeld of the Baycrest Competency Clinic reviewed the empirical research that is being carried out by the Clinic and discussed the findings and the plans for future work with the members of the Advisory Committee. The Enquiry has continued the dialogue that was established with Dr. Silberfeld and expects that the results of the work being carried out at the Clinic will help to operationalize the recommendations of the Enquiry. Later in its deliberations, the Enquiry made a site visit to the Clinic to review the recent developments and participate in actual capacity assessments.

The mailing and advertisements elicited an enthusiastic response from a number of sectors of the community. Patient advocacy groups, care providers including clinicians, medical groups and those involved in the administration of health care institutions, family members and other interested individuals and groups submitted briefs, reports and comments on a variety of topics related to competency. These submissions were circulated to the Advisory Committee and discussed at committee meetings held for that purpose. A wide range of views were expressed in these materials and were considered by the Enquiry in the deliberations leading up to the final report.

The international dimensions of competency were explored in some depth at the XVth Congress of the International Academy of Law and Mental Health which was held in Jerusalem June 25 to 30, 1989. At that meeting Richard Corley, Enquiry Research Coordinator/Administrator, and Dr. Brian Hoffman, of our Advisory Committee, presented papers and participated in a panel discussion on competency. Other members of the Advisory Committee including John Morris, Dr. Guyon Mersereau, Dr. Llewellyn Joseph and Dr. Anthony McFarthing were also in attendance and participated in a number of competency related sessions including two special meetings that were arranged to discuss the subject with leading international experts. At these gatherings a number of psychiatrists, lawyers, judges, professors and others from across Canada, the United States, and a number of European countries reviewed the manner in which competency questions are determined in their respective jurisdictions and participated in a round table discussion of these and related matters.

Also in June of 1989, the mandate of the Enquiry was expanded to include the difficult questions surrounding the determination of decisional capacity of children and adolescents. Further submissions on this subject were solicited and a special meeting of the Advisory Committee at which a panel of experts was convened to discuss these issues was arranged. During the summer Dr. Thomas McCann and Mr. Leonard Marvy were appointed to the Advisory Committee to

assist it in the consideration of the issues raised by the determination of decisional capacity in children. Mr. Oscar Johvicas was appointed to the Advisory Committee in late 1989 to replace Mr. Brian Davidson, who was no longer able to serve.

The following report reflects the suggestions of members of the Advisory Committee, the submissions received by the Enquiry and the research that has been carried out by the members of the Enquiry staff. The Enquiry wishes to thank Ms. Susan Bogie, Ms. Wendy Greenspoon, Ms. Melanie Steiner, Ms. Cynthia Vogel and Ms. Randi Zlotnik for their research assistance.

I. COMPETENCY AND DECISION MAKING CAPACITY

Competency is a pervasive, multi-dimensional construct which is an element in virtually every aspect of decision making in society and is particularly important in the health care system. Mental competency, or the capacity to make acceptable decisions, is a subset of the broader construct and is the subject of this Ministry of Health initiated Enquiry.¹⁰ For reasons that will be more fully discussed in the next section, this report prefers the use of the phrase "decision making capacity" over the word "competency".

A. CONCEPT OF COMPETENCY

Pressed for a definition of mental competency, we might say that it is the capacity to function in a particular way, the ability to process and understand information and to make relevant, well-circumscribed decisions based on that understanding. In recent years there has been a tendency for competency to become the subject of the biological and behavioral sciences with the result that psychiatrists, neuro-scientists and behavioral scientists have tried to understand "competency", to identify it, and to measure individuals' competency in a number of relative situations. However, because of a lack of clear conceptual underpinnings for defining and identifying competency and for limiting findings of incompetency, it has become a utilitarian term, one that masks the reality that the ends of legal and social stability and consistency are often being served. In this manner competency has become a value-laden concept serving the socio-utilitarian ends of assuring conformity in society, of achieving "normalcy" or "reasonable objectives."

B. THE PLAIN LANGUAGE MEANING OF COMPETENCY

That competency is a mechanism for social control is inherent in the language of conformity, normalization, and legitimation that we use to describe it. In a biomedical context, competency has become recognized as meaning the ability to understand information and to make rational decisions using such information. In plain language, however, individuals are "competent" if they are recognized as having achieved a certain level of expertise or ability in a particular area. In such cases, competency means having the ability to exercise a particular technical skill that may be evidenced by training or certain forms of testing.

¹⁰ Other aspects of competency in health care, more specifically those associated with professional accreditation have recently been examined by the Health Professions Legislation Review Committee.

In reality, competency has many different meanings that are socially informed. In some circumstances the content of what is competency relates directly to the substance of what is being evaluated. In other cases competency can be determined based on the process of decision making. In some situations competency may be just another word for "acceptable" behaviour. In still other cases the term may be applied as a way to justify certain legal decisions when the reasons are of a broader socio-economic nature. In short, competency is a fluid notion, without basis in an absolute standard, that is shaped in part by the context and consequences of the decision.

Competency relates directly to the substance of what is being evaluated when, for example, an individual is tested and upon being awarded a driver's license is determined to be competent to drive. Many legal competency determinations are of this type and address the capacity of the individual to achieve certain goals. This approach seems to be teleologically driven: to be competent in this sense means that there is a relationship established between the means (mental process) and ends (choice). This is consistent with much of recent Western philosophy which sees purposiveness and intentionality as critical elements of human action.

However, this is not the only way in which competency should be understood. There are human acts which, although purposeful, are not intentional or perhaps rational in the socially or legally normative sense. Individuals may be driven by passions and by preferences which may be without rational basis. Examples of this type include the development of religious beliefs and intense interpersonal relationships. In assessing competency in these situations the focus should be less on the belief and more on the process by which it was achieved. These are viewed as highly subjective choices where individual preferences are afforded wide latitude. Affective, intuitive and deep personal qualities are accepted as determinative in such decisions.

Another way in which competency may be understood is in the framework of what is considered to be socially acceptable behaviour. In this regard competency, by not referring to the relationship between means and ends or the process by which the decision was made, but rather the comparison of its outcome with that which is socially acceptable is heavily value laden. Competency is frequently used in this regard to exclude, differentiate and perhaps abuse certain segments of the population. The infamous use of this technique in the Soviet Union where incompetency has been used to justify the incarceration of those at odds with the dominant ideology is an excellent illustration. Many nations have

similarly used findings of "incompetency" to justify exclusion or other maltreatment of socially marginalized groups.

In still other cases competency is overtly or covertly used as a means to justify legal decisions which are based on criteria unrelated to the competency of the individual in question. An illustration of this is the landmark U.S. Supreme Court case of *Parham*¹¹ where the court held that parents may voluntarily "commit" their children to mental institutions without the need for a formal adversary pre-admission hearing. Essentially the court held that children and adolescents are incapable of making hospitalization decisions for themselves. Paradoxically, there are more complex decisions where adolescents have decision making power without prior approval of parents. For example, in many jurisdictions minors may obtain treatment for sexually transmitted diseases, drug abuse and even abortion without parental approval or knowledge. Obviously where hospitalization is concerned, other social goals such as emphasizing the primacy of the family become determinative. The conceptual muddiness, however, comes from the judiciary implying that the reasons for parental "hospitalization" of children are due to the minor's incompetency, rather than being straightforward about the social objectives that are to be advanced.

C. LIMITATIONS OF COMPETENCY

The paradox of "competency" becomes clear when we look at our inability to measure individuation in competency assessments. On the face of it, competency affirms the self. The competent person is a whole, rational agent, free to assert self determination and autonomy. We assist those who are incompetent because they are not able, by virtue of certain deficiencies, to assert self determination. However, when we attempt to understand incompetency, we discover that there are obstacles to properly delineating self determination or autonomy. Is it the ability to perform certain cognitive acts? If this were the case, then are we not extolling computer-like capabilities, that is, that one is able to perform certain machinations such as adding and subtracting, or defining certain words or phrases such as proverbs. Is it something deeper in one's internal feeling state that addresses what one is (one's "personhood") or addresses some sense of one's identity? Is it the way one integrates these feeling states into a process of self determination that is the real basis for competency? If this is the case, it may be better to look at the historical development of the individual and how that individual has acted under

¹¹ *Parham v. J.R.* (1979) 442 U.S. 584.

similar circumstances than to focus on certain cognitive capacities at any point in time.

In fact, however, "competency" is used in society as self-denying. It is a concept shaped by social expectations rather than individual preferences and feelings, the personal basis for decision making. If not properly constructed, competency assessments can clearly result in denial of the "true" autonomy of the individual by attempting to conform individual behaviour to social biases and prejudices of what is normal. In achieving these ends, competency becomes a value judgment, a conclusory term absent specific substance, process or logic. This reality creates the ambiguities that we experience in attempting to construct a system for understanding the clinical basis of competency. To illustrate, when we decide that an individual is "competent" to give an informed consent to a particular treatment, we examine the externalities of understanding, memory and compliance along with what would be considered 'standard' or rational behaviour. We do not have the tools currently to understand the deeper levels of subjective appreciation or emotional and intellectual compatibility tied to the decision to accept a treatment. The absence of the deeper level is a barrier to developing a framework for assessing competency in a range of social acts. Thus far, the techniques of neuropsychology in medical decision making are based also on relative notions of what represents normal psychology and what represents pathology.

D. THE IMPORTANCE OF "COMPETENCY"

Competency has become an enormously important concept because we have overloaded ourselves with expectations for its use in clinical decisions. Likewise, incompetency has become a slippery, ambiguous term highly susceptible to social abuse. Since we cannot carefully define competency, we describe it in terms of cognition, judgment, and insight. This allows society to shape competency in ways that serve certain social ends. While it may not always be improper to use competency to achieve social goals, we should not act as though we are understanding the individual's decision making processes, but we should be explicit about our purpose. When competency assessments serve social goals, interpretation of the client's preferences are reduced to some objective criteria heavily influenced by the values of those individuals who are engaging in the interpretation, creating the danger that competency will empower social institutions to trump the individual's rights whenever decisions appear to be outside the realm of what is "reasonably" expected.

Competency so measured becomes a value judgment not referring to any specific substance, process or logic, but solely leading to conclusions. To be declared an incompetent is to be described as lacking an essential human quality. As a result, forms of human protection become acts of charity on the part of society and cease to be a matter of entitlement or right. Finding one incompetent allows society to strip away property and personal rights. It removes the person from the community into moral and legal banishment. The determination of incompetency is even in some cases a stronger degradation of the human being than it is to be declared "criminal." Incompetency essentially designates the person as being incapable of functioning as a citizen in a civilized system of order.

Global ascriptions of competency or incompetency are often thrust on important segments of our community, particularly on the geriatric population. At a certain stage in their lives the geriatric population are concerned about their ability to live in the world, comfortably experiencing pleasure, being with loved ones, and extending their experiences in a supportive environment. Usually though, their ability to think rationally only becomes problematic when it involves acts such as disposing of a private home, or willing one's assets at one discrete moment before death. Declaring members of the geriatric population incompetent because they lack "judgment" (a highly normative term) of a socially accepted nature offends our basic ideology of upholding individual rights.

In addition to the geriatric population, we demonstrate ambivalence in our social responses to competency or incompetency of children. On a rational scale, children may be extremely lucid, but we often presumptively declare them incompetent, adhering to the distorted notion that they are not rational until such time as we declare that their emotional and cognitive capabilities have achieved the adult level. This is a myth. It is clear that children understand the risks involved in a wide range of activities, including medical treatment, and that they have strong preferences. This understanding is frequently achieved at a much earlier age than we accept.

We may argue that children lack insight and judgment, even if they have knowledge and clarity of thought. We conveniently objectify thresholds by declaring children below a certain age unilaterally incompetent, and conversely assuming that everyone beyond a certain age is competent. Even more problematic in many ways is the tendency to striate decisional capacity of children without scientific justification because of important social goals. If we look at children's capacity to make decisions and not our emotional responses, we may, to our surprise, find that

in many areas children should be emancipated much earlier than we have recognized until now.

At the extreme ends of the age spectrum, children and the geriatric population, we make presumptions about incompetency, the need to protect individuals and respect for their personhood. These presumptions need to be carefully unpacked: we speak about fully protecting the vulnerable and giving sustenance to self determination when, in fact, our agendas may be to the contrary. The "competency" parlance is full of value contradictions and global assertions which disguise social and community interests that do not enhance liberty and subvert human dignity.

E. DECISION MAKING CAPACITY

The inescapable social content of a competency determination makes the choice of language crucially important. To minimize the unwanted and unintended intrusion of social stigma, and to more clearly focus attention on functional parameters and the abilities of the person in the context of the decision to be made, we prefer the use of the word "capacity". In contrast to competency, decision making capacity is defined as the ability to make an acceptable choice with respect to a specific decision. However, while this choice of language may reduce, if only temporarily, the stigma associated with being found incapable, it does not nor can it, eliminate overt consideration of underlying social values. In the final analysis this is a socio/legal determination. This premise underlies this report's approach to the analysis of elements that could be employed in testing decision making capacity. The principles and interests that are implicated in the determination of decision making capacity will be considered so that it be clearly understood that such determinations inescapably incorporate assumptions about the nature of our society.

Mental decision making capacity will, for the purposes of this report, be defined as the capacity to make an informed choice with respect to a specific decision.¹² This vague definition is qualified by the growing recognition that mental decision making capacity is a "marginal" concept which must be evaluated with respect to the nature and complexity of the issue that is to be decided and that it may therefore be inappropriate to assert a global determination of mental decision

¹² Since it is the intention of this report to discuss some alternative approaches to definition of what are the elements that comprise an acceptable choice this term will be employed to reiterate the socially determined nature of the definition.

making capacity or incapacity.¹³ At present, tests of decision making capacity typically require the subject to be able to understand the subject-matter of the decision and be able to appreciate the consequences of making or failing to make the decision.¹⁴ In practice, while we believe the goal to be legally sound, its implementation tends to be variable and the discretionary component large. These concerns are becoming increasingly problematic as review boards, courts and other decision makers are required to give effect to the analysis of decision making capacity as a marginal construct.

This Enquiry is primarily concerned with capacity to make decisions concerning: a) personal care and in particular the medical or psychiatric treatment of the individual, b) property and financial affairs, c) the appointment of a substitute decision maker, and d) access to or disclosure of clinical records. The Enquiry has considered the issues associated with the assessment of capacity from a number of differing perspectives and has formulated criteria, a protocol and guidelines to assist those responsible for making competency assessments to perform consistent and valid assessments.

F. THE CONCEPTS OF COMPETENCY AND CAPACITY - SUMMARY

The word "competency" is understood as meaning the ability to process and understand information and to make well-circumscribed decisions based on that understanding. Although this subject has been much studied in the biological and behavioral sciences, the term competency is so inextricably linked to social norms that it has become a value-laden concept serving the socio-utilitarian ends of

¹³ The word marginal conveys, that competency is in many cases not an absolute or global state, that it may vary over time, and that an individual may be competent for one purpose but not for others. See Benjamin Freedman, "Competence, Marginal and Otherwise - Concepts and Ethics". (1981) 4 Int. J. Law & Psych. 53 and the *Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons*. See also Center for Research & Education in Human Services, "Choices and Obligations - A Look at Personal Guardianship - Policy Analysis Paper No. 3", (Toronto: Ministry of Community and Social Services, 1988) which at 9 notes that an "individual may be competent in some areas and not in others, or may not be competent with unfamiliar or complex situations even within the same area."

¹⁴ For example see the Ontario, *Mental Health Act*, R.S.O. 1980, c.262, as am. S.O. 1987, c.37, s.1(g) which defines "mentally competent" as having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent.

See also the *Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons* (Fram Committee) which specifies the following test in s.41 of the Committee's Proposed Legislation. "A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."

assuring conformity in society. The danger that findings of "incompetency" may be used to justify exclusion or other maltreatment of socially marginated groups is an ever present one which must be consciously countered to prevent the abuse of the construct.

To minimize the unwanted and unintended intrusion of social stigma, and to more clearly focus attention on functional parameters and the abilities of the person in the context of the decision, we prefer the use of the word "capacity". In contrast to competency, decision making capacity is defined as the ability to make an informed choice with respect to a specific decision. However, while this choice of language may reduce, if only temporarily, the stigma associated with being found incapable, it does not nor can it, eliminate overt consideration of underlying social values. In the final analysis this remains a socio/legal determination.

II. THE PROBLEMS ASSOCIATED WITH THE DETERMINATION OF DECISION MAKING CAPACITY

Review of Submissions

There is not a clear consensus with respect to the issues that form the subject matter of this Enquiry among the families, members of patient self-help groups, clinicians, lawyers or persons within a given socio/economic class, and between classes. As may be noted in the events reviewed in the Appendices, recent history has seen attitudes to mental health law, to psychiatric clients, the geriatric population, the developmentally handicapped, and others perceived to be of marginal competence, undergo dramatic change over the last twenty-five years. The interactions with these developments have left us all impressed in different ways with different aspects of the system at different times. The consensus about the law in this area which appeared to exist twenty-five years ago simply no longer exists. The Enquiry has considered a wide variety of viewpoints and perspectives and recognizes that in the end we cannot hope to please all interested parties. In such circumstances the best that can be done is to give all submissions careful consideration and thereby weigh and ponder all the concerns represented therein even if the results are not those that would have been preferred by the submitting groups.

It is not surprising, given the foregoing, that there is no broad consensus in the briefs submitted to the Enquiry, the opinions of the members of our advisory panel, and the attitudes existing in society as a whole, as to the appropriate balances between individual integrity and state interests. The variety of opinion relates to both substantive and procedural matters concerning decision making capacity determination and reflects the concerns discussed above. The history of psychiatry and the law over the last quarter century has seen an explosion of differing approaches, viewpoints and legal and medical developments. These have been internalized and balanced by individuals in various ways.

This problem of the diversity of approaches is compounded by the failure of many submissions to distinguish between the criteria and determination of decision making capacity, and the appropriate results of a finding of incapacity. The former is central to the work of the Enquiry; the latter, while of assistance in placing decision making capacity in a legal context, is itself at best peripheral to the work of the Enquiry. The failure to distinguish between these issues was not only prevalent in submissions from individuals, but also frequent in those from service providers and organizations dealing with the client group. This confusion may well result from the fact that until recently in mental health law, and even now outside

the psychiatric context, a determination regarding decision making capacity has not been viewed as a discrete topic in the decision to treat a marginally competent individual, but rather one factor in the decision whether or not to treat, and not entirely practically distinct from the merits of the treatment proposed, the wishes of the family, and the wishes of the client whether capable or not.¹⁵

The lack of understanding of the statutory and common law is sufficiently pervasive to cause concern. It is not clear that a better understanding of competence will be of assistance, if the role of decision making capacity determination in the legal structure is not understood by the persons who are dealing with the clients.

There are three issues upon which a broad consensus exists in the community as a whole. First and foremost, there appears to be universal agreement that individuals are presumed to be capable, absent evidence to the contrary. Some briefs went so far as to suggest that we recommend codification of this presumption in a statute.¹⁶

Secondly, as an individual's capacity may change over time, it is agreed that a finding of incapacity ought to be easily reviewable. A finding of legal incapacity should not be perpetual, but should merely extend as long as the actual incapacity of the subject persists.

Thirdly, incompetence is not to be understood in any global sense, but rather as reflecting incapacities with respect to specific decisions or areas of decision. While there is consensus on that point, it is less clear what categories are to be used in assessing capacity. In some briefs, it is clear that competence refers to a category of decisions (e.g., treatment decisions, financial decisions), while in others it would appear to refer to specific decisions (e.g., consent to a proposed treatment, or execution of a specific contract).

There was divided opinion with respect to who should perform the assessments. Almost all submissions which addressed the point suggested that

¹⁵ See, for example, *Ciarlariello v. Schacter* (unreported, Ontario High Court of Justice, file No. 7448/81, reasons released 03 November 1987), where notwithstanding the fact that there was no suggestion that the client was incompetent to consent to medical treatment, the court nonetheless considers in some detail the discussions between the client's daughter and the doctor, and the daughter's agreement that the treatment was desirable.

¹⁶ See briefs of Ontario Human Rights Commission and the Ontario Psychiatric Patient Advocate Programme.

physicians ought to have a central role in the process, although there was broad agreement that the guidelines now extant for the exercise of physician discretion were not clear enough. Some submissions argued that psychiatrists should be given a unique role, while at least one argued against such a role.¹⁷ Two related issues ought to be addressed in this regard. Firstly, in some areas there is a shortage of physicians. We have been told, for example, of a shortage of geriatric psychiatrists in Canada that will take a number of years to correct.¹⁸ We have further heard from a number of sources of the frustration that is felt by the medical community as a result of involvement with tasks perceived to be administrative or quasi-legal in nature. This suggests that it may be difficult to reconcile the physician involvement suggested by various groups including physicians, with the desire to avoid the administrative work that such a role implies.

A related problem concerns financing of the involvement of medical professionals, as explained in the following comment:

In the present perilous state of health services to the elderly, there has to be some means by which clinical input can be provided, to the legal system, and that the time of the clinician has to be paid for. Currently many physicians, are refusing to get involved in the legal process, because of the time involved, which often is totally unpaid. The result is that often times these issues are swept under the carpet, and the patient's right to appropriate health care and indirectly legal redress, is put in jeopardy.¹⁹

In order for doctors to become or remain involved in the process, appropriate avenues of reimbursement must be made available.

A number of briefs, however, suggested that the determination of capacity ought not to be left to the physician alone. According to these briefs, capacity should be determined by a team or an administrative board, consisting of members with medical, legal, and social expertise.²⁰

It was argued that the determination ought to be made by a judge and jury.²¹ This approach was criticized by the Psychiatric Patient Advocate Office

¹⁷ See submission of Canadian Committee on Human Rights.

¹⁸ Submission of Victoria Hospital Psychogeriatric Clinic (19 December 1988).

¹⁹ Submission of Victoria Hospital Psychogeriatric Clinic (13 December 1988). A similar point was made by the Psychiatric Nursing Interest Group.

²⁰ See, for example, the submissions of City of Toronto Department of Public Health, Citizens' Committee on Human Rights and the Wellington and District Public Health Department.

²¹ See brief of Don Weitz, for example. Angela Browne would also have a judicial determination for persons

(PPAO) on the basis of its inflexibility. Their submission pointed out that court determinations rely heavily on medical testimony in any event, so that the advantages of a court procedure are largely illusory. They suggest that a more flexible system be implemented, particularly when the client requires acute care, or in a situation such as a psychiatric facility where levels of capacity may change in a short period of time.²² In such settings, the PPAO advocates determination by a doctor, subject to the following safeguards: (a) unless the incompetence is obvious, a second medical opinion by a physician of the client's choosing; (b) notice to the client; (c) an automatic visit by an independent professional to advise the client as to their rights; (d) right of appeal, ultimately to the regular court system; (e) automatic reviews of a finding of incompetence.

The desirability of rights advice was propounded by the Manic-Depressive Association of Metropolitan Toronto. The PPAO notes that the provision of such a service, while in their view an essential safeguard, does pose practical administrative problems, particularly for individuals not housed in large institutions.

The involvement of families in the decision making process was generally viewed favourably.²³ It was suggested that involving families in discussions would generate a better understanding of the context of the decision to be made in the subject's life history, rather than placing families in an actual decision making capacity. Even among those who favoured family participation, however, there was occasionally a warning that the views of the family might be tainted by motives not reflecting the best interests or wishes of the subject. These briefs made the point that the views of the family could not necessarily be accepted at face value.

A number of briefs expressed concern that whoever makes the decision, the system must be sensitive to individual needs, and must avoid the marginalization of individual clients, and respect client dignity. One brief provided the following anecdote, to illustrate how such values may be lost:

I worked as an enumerator for one of the elections. Upon arriving at another group home, the door was answered by an elderly staff person. While the residents were sitting in the kitchen, she pointed

outside the hospital setting.

²² The concern that any system implemented ought to be flexible was broadly held. Usually, the comments made were in the more specific context that a finding of incapacity ought to be readily reviewable, upon a change in the condition of the subject.

²³ See, for example, the submissions of the Ontario Friends of Schizophrenics, the Manic-Depressive Association of Metropolitan Toronto, the Wellington-Dufferin District Health Council, and the Canadian Mental Health Association (Peterborough).

to them, and told us that they were "incompetent" and "retarded", and therefore couldn't vote. Upon calling the returning office, I was advised to enumerate those residents who appeared to understand the meaning of voting and enumeration. As I did this, one of the female residents almost cried as she asked me why the staff person said she was not allowed to vote. She voted all her life. Not surprisingly, most of the people we talked to there were quite lucid and understood what was going on.²⁴

Concern was expressed about cultural biases based on age, race, sex, sexual orientation, ethnic origins, and economic class. While these issues were usually raised in the context of the content of the test to be applied,²⁵ this context is difficult to divorce from the individual doing the testing. Several briefs also pointed out that biases of the individual doing the testing may result in the client being accorded more or less credibility. This biased orientation would in turn impact upon the outcome of the test. The issue is not simply one of the standards contained in the test, but also of ensuring that all individuals are accorded equal respect and credibility as they are evaluated for decision making capacity.

Consistent with these concerns, the Hospital for Sick Children pointed out that the terms of the explanation provided are significant. An attempt ought to be made to explain the proposed treatment in terms and in language that the individual can understand.

Concern about client credibility is further reflected in the submission of the Citizens' Commission on Human Rights. They cite an American study where an examination of one hundred randomly selected psychiatric clients, forty-six had undiagnosed medical illnesses that either caused or exacerbated their psychiatric illnesses. The ramifications of such a statistic are broad; relevant for consideration here is the effect that the undiagnosed illness may have on client credibility. They argue that what are labelled as "delusions" by staff may in fact be very real symptoms of medical illness. They argue that a finding of incapacity ought to be made only after a full physical examination of the individual has been performed.²⁶

²⁴ Brief of Angela Browne at 3.

²⁵ See, for example, the submissions of the Hospital for Sick Children, the Ontario Association of Professional Social Workers, the Manic-Depressive Association of Metropolitan Toronto, the Coalition for Gay and Lesbian Rights in Ontario, Don Weitz and Angela Browne. The importance of cultural values in this context will be discussed *infra*.

²⁶ See also the briefs of the Ontario Association of Professional Social Workers and Mrs. Sandra Kantymir, a social worker. The requirement of diagnostic tests prior to determination of capacity raises the additional problem of how capacity is to be determined for purposes of consent to the diagnostic test.

Other briefs argued that the purpose of the examination ought to be explained to the client.²⁷ The Manic-Depressive Association of Metropolitan Toronto stated:

The patient knows his/her own body and its reaction to various medications. Respect should be given to this fact by the professionals when assessing decision making capacity with respect to treatment.

This reflects the belief that a certain basic respect must be paid to the client, the client's knowledge of and right to control his or her own body, and the client's right to be informed of the processes being performed.

A number of briefs discussed the occasion which should trigger an assessment of capacity. The Psychiatric Patient Advocate Office argued that as a finding of incapacity is an intrusion into the life of the client and into the civil liberties of the client, it was important to ensure that it was the least intrusive measure possible under the circumstances. The Ontario Human Rights Commission made a similar submission, arguing that a determination of mental competence ought not to "interfere with the freedom of those who know what they are doing and appreciate the consequences of their acts, or who can do so with assistance".²⁸

Arguably, these positions are consistent with the submission of the Ontario Medical Association that individuals who understand that they trust their doctor should be considered capable, even if they do not understand all the technicalities of the proposed treatment.

Much more controversial is the situation, presented by the Psychiatric Patient Advocate Office as the status quo, that a determination of competence is now only triggered by a firm refusal of treatment by the client. Under this scenario, numerous incapable clients are being treated because they are not actively opposing treatment. The PPAO and others,²⁹ suggest that routine assessments of decision making capacity be made. The Ontario Human Rights Commission explained their concerns about such a system in the context of a law which would have exempted the need for consent when vaccinating clients:

The Commission's concern was that the exemption effectively denied mentally incompetent patients the options available to competent individuals in the same circumstances. That is, it denied them the right, through the assistance of a guardian or advocate, to challenge an assessment of them as mentally

²⁷ See, for example, the brief of the Ontario Association of Professional Social Workers.

²⁸ Emphasis in original.

²⁹ See, for example, the brief of the Wellington-Dufferin District Health Council.

incompetent in the first instance, to challenge a medical assessment leading to the recommendation of immunization, to obtain a second opinion on any of the above assessments, and to refuse treatment.

* * *

As I mentioned above, persons who are mentally impaired or incapacitated are considered to have a handicap and are thus entitled to the same medical services and opportunities to consent to treatment that other individuals have.

In effect, the concerns of the Ontario Human Rights Commission and the Psychiatric Patient Advocate Office are that treatment involves a choice, and must be preceded by a capable decision to accept the treatment. The treatment of incapable acquiescing patients ignores the requirement that a capable choice being made prior to treatment.

As to the test itself, there appears to be broad agreement in the briefs that capacity is to be measured according to the specific functional abilities of the client rather than on the basis of the appropriateness of the choice. A number of briefs concurred with this viewpoint.³⁰

Many briefs from the families of persons with psychiatric problems were not entirely clear on this point. The concerns expressed in these briefs were that individuals requiring treatment were not receiving treatment because of their competent refusal. Treatment refusal was clearly perceived as the problem. However, the briefs tended to argue two points: that these individuals ought to be treated notwithstanding their capable refusal of treatment and that the standards applied to the patient's functional abilities were flawed, because, for example, of an inadequate concern for the client's delusional state. Physicians, as well, were very concerned about the effect that the standards of competence have on whether treatment could be given.³¹

The briefs addressing the point argued that age ought not to be used as a pivotal factor to determine capacity, either regarding seniors or children.³² The level of functioning, which should be the governing standard for competence, was

³⁰ See, for example, the briefs of the Wellington-Dufferin District Health Council, the Ontario Association of Professional Social Workers, Angela Browne, and Don Weitz.

³¹ See, for example, the briefs of the Ontario Medical Association and of Provincial Psychiatric Hospital Medical Directors Group.

³² See briefs of the Psychiatric Patient Advocate Office, the Canadian Mental Health Association (Peterborough), the Hospital for Sick Children, and Angela Browne.

discussed in various briefs. These standards³³ are considered in more detail later in this report.

In terms of the level of cognitive understanding which ought to be required, a number of briefs preferred a relatively high standard. The Psychiatric Patient Advocate Office spoke in terms of a "considered, consistent choice over a reasonable period". The Ontario Association of Professional Social Workers spoke of "the ability to weigh the options and understand the consequences of selecting one or more or none of them".

The most common method of assessing the functional abilities of an individual is the mental status examination. A number of submissions were concerned about the use and implementation of the standard mental status examination in the context of decision making capacity determination. The Ontario Human Rights Commission was concerned that such an examination might be too perfunctory. The Psychiatric Patient Advocate Office suggested that because of a wide variety of factors including the effects of medication, confusion, the manner and amount of factual information given during the interview, delusion, and interpersonal concerns, the decision making capacity of an individual might fluctuate over very short periods of time. They therefore argued that a determination of capacity might well require more than one interview.

A number of briefs expressed the concern that the mental status examination evaluated the individual in a situation removed from the individual's own circumstances. As a way of correcting this shortcoming, it was argued in a number of submissions that, alternatively, the assessment of capacity should include a family history.³⁴ Other briefs argued that the examination ought to occur in the context of the client's daily living, rather than in an institutional setting.³⁵

³³ The particular tests referred to are widely cited to L.H. Roth, A. Meisel and C.W. Lidz, "Tests of Competency to Consent to Treatment". (1977) 134:3 *Am Journal of Psychiatry* 279.

³⁴ See, for example, the briefs of the Ontario Association of Professional Social Workers and the Wellington-Dufferin District Health Council.

³⁵ See, for example, the briefs of the Ontario Association of Professional Social Workers and the City of Toronto Department of Public Health.

A number of briefs argued that any test used must be culturally neutral.³⁶ Distinctions based on race, ethnic origin, class, sex, sexual orientation, language spoken, and literacy ability were roundly criticized. Apart from suggestions that explanations ought to be given in a language that the client understands in terms simple enough that the client can comprehend them, there was little concrete advice on how a culturally neutral test was to be developed.

A particular problem noted in a number of briefs concerned the delusional individual. In general, consistent with the general view of the required standard of cognitive functioning, the briefs argued that persons whose delusions affected the decision to be made ought not be found capable. These remarks must be taken in the context of the concerns about client credibility raised by a number of briefs. It is a fair question to ask how the evaluator is to be sure that a belief of a client is in fact a delusion.

A particularly contentious issue is the "delusion" of the client that he or she is not in fact ill. The following comments from the brief of the Psychiatric Patient Advocate Office state the problem:

The risk is the temptation to equate the standard [of competence] with the need to totally agree with the attending physician's diagnosis and proposed treatment in order to be competent. By that tautological measure, any patient who is inclined to question a diagnosis or refuse treatment is incompetent by definition. This interpretation is as unsatisfactory a test as is that requiring only intellectual understanding.³⁷

³⁶ See, for example, the briefs of the Ontario Association of Professional Social Workers, the Manic-Depressive Association of Metropolitan Toronto, the Coalition for Gay and Lesbian Rights in Ontario, the Hospital for Sick Children, Angela Browne and Don Weitz.

³⁷ In a recent (June 1, 1989) District Court decision *McKay v. O'Doherty* (1989), [1989] O.J. No. 965 the Court made the following finding with respect to the requirement for appreciation:

Counsel for the appellant takes the position that the three elements involved require only an intellectual outward understanding and not a personal insight into one's own situation. Counsel for the respondent argues that unless a person has an insight or personal awareness of the existence of the mental disorder that it is not possible to appreciate the consequences of giving or withholding consent.

DISPOSITION:

The giving or withholding of consent is not something that should arise in the abstract but should relate to the awareness of an existing condition. An ability to appreciate the consequences of giving or withholding consent could hardly be considered an informed consent or withholding, if the person denies an existing condition. Denial of the illness places the appellant in the position where she cannot appreciate the consequences of the medications as related to her personal needs.

A number of suggestions were made to deal with this problem. The Psychiatric Nursing Interest Group suggested that clients be able to recall the name(s) of their diagnosis(es). The difficulty with such a suggestion is that it remains largely a test of cognitive ability, rather than appreciation. The Psychiatric Patient Advocate Office supplied the following possible solution:

When we say the patient must apply reasoning to his or her own situation, it is enough if the person is aware that he or she has a problem with thought, mood or personality which affects his or her ability to function in the community.

A number of briefs suggested that many clients fit in the grey area between competence and incompetence. It was suggested that, given the varying benefits and risks to various treatments, a single standard of capacity might not be appropriate. A number of individuals suggested that a sliding scale for the standard of understanding might be appropriate. The Ontario Medical Association suggested that treatments which were relatively intrusive, or had an unfavourable "benefit/harm ratio" should require a relatively high level of capacity. The City of Toronto Department of Public Health suggested that a flexible standard apply, according to the "seriousness" of the treatment, the Psychiatric Patient Advocate Office based its flexible standard on the "seriousness, intrusiveness and risk of a proposed treatment". Mr. Don Weitz argued that a relatively low standard of competence might be applied for managing small estates. In matters of estates generally, both large and small, the scale is in general easily definable by the amount of funds in the estate. In treatment matters, adopting an appropriate standard is more problematic as the criteria suggested are likely to be highly subjective. On a certain level, this just creates another complication in the assessment of decision making capacity: who decides what standard of competence is to be applied, and on what terms? Is this a decision which is legally reviewable?

The above were among the concerns identified to the Enquiry and to which attention was given when preparing this report. Issues identified in submissions will be discussed further in light of the recommendations of the Enquiry later in this report.

A. CAPACITY ASSESSMENT PROBLEMS - SUMMARY

Attitudes toward psychiatric clients, the developmentally handicapped, the geriatric population and others of questionable capacity have undergone dramatic changes over the past twenty-five years. As a result, there are significant variations in the attitudes held by those involved in the health care system. Care providers and clients' families generally favour the reduction of impediments to treatment,

while patients and their representatives favour the expansion of effective procedural safeguards. These diverse views give rise to significant differences of opinion with respect to the role of the medical profession, the judicial system, rights advisors and advocacy in the assessment of capacity. Concerns have been expressed about the impact of cultural biases arising out of differences in age, race, sex, sexual orientation, ethnic origins, and economic class on the assessment process. The difficulties inherent in the assessment of delusional individuals has been identified as another subject of particular concern. Variations in capacity over time and with respect to subject matter of the decision present practical problems for effective assessment. These and other related concerns were among those communicated in the submissions considered by the Enquiry.

III. MARGINAL DECISION MAKING CAPACITY

A. DECISION MAKING CAPACITY V. COMPETENCY

In recent years, decision making capacity has been perceived as a marginal construct. The use of the word "marginal" emphasizes that competency must be understood and evaluated in terms of specific situations or types of decision. Individuals who are not capable with respect to one type of decision may be capable to make another. In practice, however, the difficulties associated with the assessment of the limits of decision making capacity and confusion about the meaning of the concept, have tended to impede its implementation. As a result individuals have been either considered globally competent or incompetent. However, in order to properly recognize the limits to decision making capacity, it is necessary to consider the ways in which partial decision making capacity may be recognized.

B. MARGINAL DECISION MAKING CAPACITY BY CLASSES OF SITUATIONS

There are a number of different classes of situations within which decision making capacity may be tested; pursuant to each of these different classes, different parameters need to be assessed and considered. These include the four listed in the terms of reference and a number of others:

1. The capacity to make treatment decisions,
2. The capacity to make decisions about property,
3. The capacity to appoint a substitute decision maker,
4. The capacity to make decisions about medical records,
5. The capacity to care for self,
6. The capacity to care for children,
7. The capacity to waive legal rights, such as right to counsel,
8. The capacity to instruct counsel, and
9. The capacity to have knowingly committed a crime.

While there are obviously areas of overlapping decisional capacity within the above classes, it is also possible to further subdivide many of the classes of decisions in terms of the requirements of a particular decision.

C. CAPACITY TO MAKE A SPECIFIC DECISION

Within a class of decisions, e.g., financial, factors such as the complexity of the information to be considered in making a specific decision, and other contextual

considerations suggest that there is not a single measure of decision making capacity that would apply to all decisions within the class. Therefore, the construct of decision making capacity should reflect the functional requirements of the specific decision.

There are a number of different parameters that could be used to discriminate between specific decisions within a class. Although the consideration of the outcome may be objected to by some individuals, different standards might be appropriate based on the seriousness of the outcome. For example, most would agree that a higher standard be used to consent for neuroleptics than for aspirin. Similarly, an individual might be considered to be competent to purchase groceries but not commodity futures or speculative real estate. The specification of the parameters to be considered in this regard will be discussed later in this report.

D. VARIATIONS IN CAPACITY OVER TIME

An individual's decision making capacity can vary over time for a variety of physiological and psychological reasons and also as a result of learning and increased familiarity with the subject matter of the decision. These factors suggest that it may be necessary to make more than one assessment in order to determine both the extent and variability of an individual's capacities. Additionally, every effort should be made to help maximize an individual's performance. Efforts to facilitate the best performance possible by the subject could include provisions for assessing individuals in a comfortable environment using the language of their preference.

E. CAPACITY TO MAKE A SINGLE, OR SERIES OF DECISIONS

In practice, assessments of marginal capacity may be further subdivided between those situations in which an assessment will be used to determine capacity to make a single, discrete decision, such as to consent to a surgical operation, and those for which it would be desirable that the assessment apply to a series of similar decisions to be made over a period of time, as might be the case with respect to individuals who are marginally competent to care for their property. While in the former case it makes sense to assess the individual specifically in the decisional context, in the latter case it would be more efficient if a more general assessment of the individual could be applied to a number of decisional contexts.

F. MARGINAL CAPACITY - SUMMARY

The more complicated cases with regard to assessing capacity are those in which the individual appears capable of making some decisions but not others. Proof of global incapacity as, for example, would be satisfied by an unconscious or uncommunicative individual, is the least problematic subset of the range of possibilities and may be easily identified and appropriately dealt with. Bearing in mind that in all other cases individuals' capacities are marginal, the desirability of allowing individuals to exercise the greatest possible measure of control of their bodies and their lives demands that tests of decisional capacity accurately reflect the requirements of a particular decision. This in turn requires that such parameters be clearly ascertained and assessed in an appropriate manner.

IV. PRINCIPLES UNDERLYING THE DETERMINATION OF DECISION MAKING CAPACITY

Three competing interests are implicated in the determination of mental decision making capacity:

1. Individual rights, including the rights to dignity, autonomy and to self determination,
2. The individual's best interests as determined by the state in the exercise of its *parens patriae* powers, and
3. The interests of the community in the promotion of broader state concerns. These include the protection of all citizens and the state's legitimate interests in achieving administrative simplicity, efficacy and efficiency in the care of its members.

A. INDIVIDUAL RIGHTS

While human rights are given a level of protection which varies from country to country, most civilized states are increasingly elevating the rights of the individual above the interests of the community. Since the Second World War, there has been increasing national and international attention paid to human rights, including the rights of those involved in the mental health care system.

In Canada the enactment in 1982 of the *Charter*³⁸ confirms the priority to be given to individual rights,³⁹ although it must be noted these rights are not accorded absolute protection but are subject to the limiting and override provisions contained in sections 1 and 33. The need to bring all legislation into conformity with the *Charter* has led to a number of changes being made to laws such as the *Ontario Mental Health Act* (as is discussed in Appendix V on Historical Developments in Ontario). The "legalization" of the involuntary commitment and competency review processes under the *Ontario Mental Health Act* and the development of the "patient advocate" and "rights advisor" programs in the province

³⁸ Canada, *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c.11.

³⁹ More specifically the individual rights that are protected under sections 2 to 15 of the *Charter* are generally given supremacy under section 52 over the legislative enactments of both the provincial and federal governments (as specified in section 32).

may be seen as reflecting the growing importance ascribed to such rights by Canadian law.

This trend is not, however, a uniquely Canadian phenomenon. The need to protect individual rights and freedoms was brought most sharply into focus by the atrocities that were committed during the Second World War. In the aftermath of the war, the United Nations was formed and through the adoption of its Covenants on Human Rights, international codifications were provided of many basic human rights. Prior to the passage of the *Charter* both the federal government, with its *Bill of Rights*,⁴⁰ and a number of provinces, through passage of human rights legislation, demonstrated an increasing commitment to such ideals. Internationally, the *American Bill of Rights* and the *European Convention for the Protection of Rights and Fundamental Freedoms*, are evidence of the primacy attributed to such interests.

When viewed in a longer term perspective, the increasing emphasis on the concept of the individual as the bearer of rights would appear to follow from the rise of contractualism which has gradually supplanted the more status oriented structures which were dominant in pre-literate, feudal societies. While in the earlier eras individuals' rights were largely a function of their formal and material status within the society (birth, title, land holdings, etc.), the rise of abstract symbolic reasoning and contractualism led to the recognition of universal egalitarian ideals and to the presumptions of formal equality that underpin the Canadian *Charter*.⁴¹

As was noted in the Psychiatric Patient Advocate Office submission, the *Mental Health Act* serves patients' autonomy by not permitting forced treatment of competent patients, by allowing a patient who is competent to do so to appoint a substitute decision maker, and by obliging the substitute decision maker to act on "wishes expressed when apparently mentally competent", if any are known.

In the context of decision making capacity determination a few observations will be made with respect to the implications of the libertarian principles that are advanced by the enhancement of individual rights.⁴² Although there are inherent

⁴⁰ Canada, *Canadian Bill of Rights*, S.C. 1960, c.44.

⁴¹ J.C. Smith and D.N. Weisstub *The Western Idea of Law* (Toronto: Butterworths, 1981).

⁴² It should be noted that the complexity of the subject matter serves to qualify any blanket assertions that may be professed as flowing from the application of the principle in any particular context.

limitations on such general assertions, the following summarize the more basic observations:

1. Individual rights tend to be associated with the observance of due process safeguards and legal procedures. Lawyers are usually seen as being the protectors of individual rights and employ a legalistic approach to decision making capacity determination.⁴³
2. Relationships are presumed to embody contractual principles; more specifically they are based on the assumption of consensual arrangements between equals.
3. The presumption of equality rules out the use of an individual's status as a basis for determining decision making capacity. Similarly, the reliance on procedure as the basis of a correct decision rules out the consideration of the outcome of a decision⁴⁴ as an element in the test.⁴⁵
4. As was noted in the Manson report,⁴⁶ the increased emphasis on individual rights in the psychiatric context has been linked to the development of a more adversarial relationship between the patients and psychiatrists and while this is not an inevitable consequence, the effective shift of power from the "authorities" to the "individual" makes it likely for this to occur.⁴⁷

⁴³ The "legal" approach may be distinguished from the "medical" approach insofar as the law exists to impartially arbitrate between equals who are presenting competing opinions, relying upon "legal" processes it determines the "correct" answer from what must be, by definition, a relativistic position. Medicine on the other hand refers to the superior knowledge and presumed benevolence of the expert to validate that which it defines as the "correct" answer.

⁴⁴ The principle that individuals' decisions to act in ways that seem objectively detrimental to their best interests must be respected was clearly evidenced in *Malete v. Shulman* (1987), 63 O.R. (2d) 243, [1987] O.J. No. 1180 (H.C.). For further discussion of this case, see Appendix IV.

⁴⁵ If stated as a strict rule this requires that the test be completely symmetrical. This meaning that it would not favour the more "reasonable" outcome over the less reasonable one, that it would employ the same test irrespective of how important was the decision at issue and irrespective of the certainty of the outcome of the decision.

⁴⁶ Manson, "Advocacy in Psychiatric Hospitals - Evaluation of the Psychiatric Patient Advocate Office", 1987 at 105-124.

⁴⁷ This being especially true because doctors are trained to act in what they believe is in the best interest of the patient and to believe that their expertise makes them more competent than the patient to make decisions concerning his or her treatment.

B. PATERNALISM, BENEFICENCE AND PARENS PATRIAE

Paternalistic intervention to assist the incompetent has historically been justified as an exception to the dominant principles favouring individual autonomy.⁴⁸ The inability of incompetents to form fully rational intentions, or to act in their own interests in the manner expected of "normal" citizens, is seen as vindicating the intervention of the state to protect them from the consequences of their own incapacities. In law the Crown's *parens patriae* jurisdiction was based on the principle that the King, as *parens patriae*, had a duty to care for those who were not able to care for themselves, historically referring to children and the mentally incompetent. In Canada the *Eve*⁴⁹ case represents the most authoritative judicial statement pertaining to the basis and the scope of the *parens patriae* jurisdiction. In that case it was held that this jurisdiction, vested in the superior courts, was to be exercised exclusively for the benefit and protection of the incapable person and not for the benefit of others. While there are differing definitions that can be assigned to the words "best interests",⁵⁰ the legislature has, in the *Ontario Mental Health Act*,⁵¹ provided substitute decision makers with guidance in the form of an

⁴⁸ R. Sherlock, "My Brother's Keeper? Mental Health Policy and the New Psychiatry". In D.K. Kent-Smith, S.A. Salladay and P.A. Miya (eds.), *Ethics in Mental Health Practice* (Orlando: Grune & Stratton Inc., 1986) at 184-185 cites Kant and Mill as excluding children and the insane from the "liberty" principle, and quoted Mill for the proposition that:

Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury. ... a ruler full of the spirit of improvement is warranted in the use of any expedients that will attain an end, perhaps otherwise unattainable."

⁴⁹ *E. (Mrs.) v. Eve* (1986), [1986] 2 S.C.R. 388, [1986] S.C.J. No. 60. For further discussion of this case, see Appendix II and Appendix IV.

⁵⁰ For example, different formulations of best interest may choose to include or exclude the subjective preferences of the individual in question, may simply reflect the undifferentiated, objective interests of a "reasonable person", or attempt to ascertain the objective best interests of a person possessing the objective characteristics of the incompetent person.

⁵¹ The Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended), s.35(5) provides the following assistance with respect to the meaning of "patient's best interests":

- (5) A person authorized to give or refuse consent on behalf of a patient shall consider the following factors to determine whether a specified psychiatric treatment and other related medical treatment are in the best interests of a patient,
 - (a) whether the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
 - (b) whether the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
 - (c) whether the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and

expanded definition of this term. The therapeutic alliance, and the objectives of medical treatment generally, may be thought of as advancing interests that are akin to the *parens patriae* duties of the state and reflect the same paternalistic concerns, namely that of furthering the best interests of the incompetent individual.

In the health care context the tendency toward the imposition of medically defined "best interests" on the marginally capable is increased by the respect accorded to the opinions of medical experts by the other actors in this context. The tendency to defer to medical authority is evidenced by the codified requirements for medical or psychiatric testimony which accompany the decision making procedures with respect to many legal and quasi legal questions in this area, as well as the courts' reliance on the testimony of medical experts when making such determinations.⁵² Doctors and psychiatrists have special skills with respect to the diagnoses and assessment of medical and psychiatric conditions such that lawyers, judges and others are inclined to defer to their expertise.⁵³

However, notwithstanding the acknowledged skills of the experts with respect to the technical questions encountered in this area, the complex interplay of cultural, social and other forces make it very difficult to accurately predict the course of treatment or intervention that will in fact give rise to the best results. Indeed in this regard it has been asserted that:⁵⁴

(d) whether the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c). 1987, c.37, s.11.

⁵² Psychiatric Patient Advocate Office, "Submission to Weissstut Inquiry on Competency Determination", May 1989 at 8 notes, "In jurisdictions in which capacity is determined by a judge, we note that court findings of incompetency rely primarily on physician testimony."

⁵³ In this regard competency to make medical or psychiatric decisions may be considered to be one dimension of the multi-dimensional competency matrix which helps to shape the relationships and relative power of individuals in society. Competency or capacity within any one dimension may be seen as forming a continuum ranging from absolute incompetence at one end to absolute knowledge and rationality (a sort of super competence) at the other, and along this continuum the wider the competency gap between any two points the greater the relative power of the more competent over the less competent. Within the medical competency dimension while lawyers, judges and average lay persons are considered to be normally competent, and therefore relatively more competent than patients whose competency is in question, the medical profession is seen (by virtue of education and professional accreditation) as being super competent and therefore more competent than average persons and *a fortiori* with respect to the persons that are less competent than average.

⁵⁴ Center for Research & Education in Human Services, "Choices and Obligations - A Look at Personal Guardianship - Policy Analysis Paper No. 3" (Toronto: Ministry of Community and Social Services, 1988) at 5 quoting from D.T. Jost, "The Illinois Guardianship for Disabled Adults Legislation of 1978 and 1979: Protecting the Disabled from their Zealous Protectors". (1980) 57 Chicago Kent Law Review 1087 at 1088.

Research has shown that protective intervention in the lives of mentally or physically disabled persons can cause a higher incidence of deterioration and death than would result without interventions, particularly if such intervention leads to institutionalization in a nursing home or mental hospital.

Such considerations tend to highlight the complex interrelationships which must be evaluated in the course of defining the "best interests" of an individual in the social context, and the practical difficulties that may be encountered if such concerns are to be employed as factors in tests of capacity.

In the final analysis, despite the practical difficulties, the balancing of paternalistic against individualistic interests is a social decision that must reflect the legal and philosophical context in which it is being made. In this regard while the *Charter* serves to protect a number of individual rights, these rights are not accorded absolute protection but may be limited by section 1 and legislatively overridden under s.33. The decisions of Review Boards and of the courts, in practice,⁵⁵ demonstrate an awareness of this social role and of the need to balance the interests in a responsible manner.

In its submission the OMA noted the differences between the Canadian and American approaches to the balancing of individual rights against such concerns as universal health care and suggested that Canadians place a relatively higher value on the collective interest in universal health care than do Americans.⁵⁶ Given that there cannot be a single "correct" response to the need to balance these interests, such issues can only be characterized in terms of the interests represented and be left for resolution by the appropriate legislative and legal processes.

C. COMMUNITY INTERESTS

The interests of the community in the promotion of broader state concerns may be distinguished from its *parens patriae* interests insofar as they include advancement of the concerns of the collectivity for the individual, as opposed to the narrower "best interests" of the individual in question.⁵⁷

⁵⁵ For example see *Re Howlett and Karunaratne* (1988), 64 O.R. (2d) 418, [1988] O.J. No. 591 (Dist. Ct.) in which the court considered the *Charter* interests in the course of finding a patient to be incompetent to make treatment decisions.

⁵⁶ Ontario Medical Association, "Ontario Medical Association Submission to the Weisstub Enquiry on Mental Competency", May 1989 at 4-5.

⁵⁷ It is apparent however that these interests cannot be surgically divided as the community's broader concerns obviously include the same "best interests" of the individual that is promoted under *parens patriae*. In this

The state has the ability to control deviant or dangerous individuals through its penal or civil committal powers. It has the primary interest in the creation of an efficient and administratively workable community. Insofar as the assessment of capacity can affect such concerns, it represents the state's primary interest in the determination of decision making capacity. These concerns include the following:

1. to avoid uncertainty with respect to the determination of capacity and the consequences that flow from this determination;⁵⁸
2. to preclude the unnecessary imposition of an assessment of an individual's capacity;
3. to avoid depriving individuals of the rights which are lost as a result of a finding of incapacity;
4. to prevent individuals from acting in a manner that is contrary to their best interests as a result of a mental incapacity; and
5. to minimize intervention in individuals' lives and the transaction costs, both human and financial, that accompany such interventions.⁵⁹

D. UNDERLYING PRINCIPLES - SUMMARY

Practical difficulties aside, the integration of personal autonomy, "best interests" and community concerns must reflect the legal and philosophical context in which it is being performed. Since there is not, and cannot be, an objectively "correct" specification of this integration, one must attempt to structure the testing of decision making capacity in such a manner that the applicable social values, as

regard one can only distinguish the basis and orientation of the concern and not its substance.

⁵⁸ Consequences of uncertainty include possible confusion and/or legal liability with respect to the granting of consent to medical or psychiatric interventions, potential invalidity of contracts made with a person lacking capacity, possible invalidity of the appointment of a substitute, invalidity of consent to disclosure of medical records, etc.

⁵⁹ While the financial costs that are associated with complex assessment, review and appeal procedures are relatively self evident, the costs, in human terms, to those involved in adversarial capacity assessment proceedings can be very significant but hard to quantify. Interference with normal therapeutic doctor-patient relationships, families and other social structures is often a systemic by-product of procedures established to deal with certain problem situations.

decided through the appropriate democratic processes, are incorporated and reflected in both the substance and procedure of the test.

At present, although this integration favours individual autonomy and, therefore, requires that presumptions, burdens, etc. favour the protection of individual rights, clear evidence of functional incapacity will rebut the presumptions and facilitate an intervention to protect the "best interests" of the individual in question. The entire testing process must reflect the autonomy and "best interests" principles while conforming to social needs for proportionality, administrative simplicity and relevancy of decision making.

V. THE INTERESTS OF THE PARTIES AND THE ALLOCATION OF DISCRETION

A. THE PARTIES

Individuals whose capacities are in question have obviously the greatest interest in the outcome of the determination, as negative outcomes deprive them of the power to make the decision(s) in question. Typically, this will result in their being given medical or psychiatric treatment that they do not want,⁶⁰ or losing control over their financial resources, and other aspects of self determination.

Lawyers', patient advocates', and rights advisors' interests are in many respects derivative from those of the individual they represent, insofar as members of this group serve to facilitate the individuals' exercise of their legal rights. This group may however be distinguished in terms of the social and economic concerns which motivate them, which may be different than those of the individual for whom they are acting.

Family, friends and others outside the medical/legal systems who are close to the individual in question represent a wide range of interests, some of which are congruent with those of the individual, others of which may be in opposition to the individual.

Professional care givers, whether medical, psychiatric or other, are seen as acting in response to a number of forces. In this regard the reliance on expert medical testimony in forensic situations, involuntary commitment decisions and competency determinations places clinical staff in a position of conflict with regard to the fiduciary duty owed their client, and their deference to the necessary integrity of the decision making body. Other potential conflicts arise out of the desire to act in the expertly informed "best interest" of the client in the face of his or her contrary wishes.

Commercial suppliers of drugs and other elements of medical and psychiatric care have clearly identifiable interests in maximizing the sale of their products.

⁶⁰ The Psychiatric Patient Advocate Office, "Submission to Weisstub Inquiry on Competency Determination", May 1989 at 17 noted that "Patients are often well aware of which medications and dosages are most helpful and have fewest side effects." The submission also reviewed the adverse side effects of the chemical treatment of mental illness including such permanently debilitating effects such as tardive dyskinesia. A stronger negative view was expressed in "Peer Advocate - A Voice of Former Psychiatric Inmates & Survivors of the Neuropsychiatric System", April 1989 which characterizes such unwanted treatment as "chemical and technological rape by doctors".

Government and agencies of the government tend to pursue the policies that are dictated by the group in power and by the dynamics of the bureaucratic structure.

B. THE INTERESTS OF THE PARTIES AND THE ALLOCATION OF DISCRETION

When considering alternative criteria for evaluating capacity it is necessary to critically evaluate the full range of social concerns and motivations as potentially influencing the parties involved.

Being labelled 'incompetent' is an extremely stigmatizing, and damaging experience.⁶¹

It implies that the whole person, and not just a small segment of one's character, isn't working properly. Such a stigma has severe consequences for the patient. This label not only facilitates interested family members in gaining ultimate control over one's personal property and treatment decisions, it renders one as being somewhat of a less valuable member of the community.

Alternatively, allowing an incapable individual to make decisions may be highly detrimental to his physical, mental, financial or social well being.

Lawyers, patient advocates and rights advisors' employment and remuneration are derived from the promotion of an individual's rights through whatever procedural forums that are available to them. Structurally they have a vested interest in expanding the scope of due process and other protections that are available to the individual, irrespective of whether or not these actually advance the interests of the individual. The increased legalization of psychiatric treatment has been seen by care providers as changing the orientation of hospitals from treatment, to liability avoidance and paperwork.⁶² The costs, both direct and indirect, of such procedures are substantial and at the same time very difficult to

⁶¹ Angela Browne, "Submission to the Enquiry on Mental Competency", April 7, 1989 at 2.

⁶² Manson, "Advocacy in Psychiatric Hospitals - Evaluation of the Psychiatric Patient Advocate Office", 1987 at 100-101 noting the increased use of the Review Boards that had arisen with the introduction of patient advocates, cited psychiatrists' comments noting that "Our paperwork has increased 20 fold. The Review Board takes at least a full day ... I had spent 5-6 hours in a week on a client but not with him. This client questioned me: on this and so did the family." Nurses' concerns with avoiding potential legal liability were also noted in this regard.

accurately assess.⁶³ The manner in which advocates attempt to empower individuals also serves to create dependency on the advocate while at the same time reducing the power that medical authorities have over the individual. With respect to capacity determinations, advocates may be expected to favour a system of criteria which serves to reduce the discretion of the medical assessor while facilitating a review to which the principles of natural justice and due process would apply.

There are many potential conflicts which may arise between the family and an individual. In the case of capacity to make financial decisions, family members will often stand in a position of economic conflict with the individual. This is especially true in cases of members of the geriatric population whose actions may serve to reduce the size of the estate that will be left to family members.⁶⁴ In addition, economic and other concerns are put in issue, in that there is a burden that caring for disabled individuals places on family members, thus giving rise to a desire to have an individual found incapable and in need of professional care in order to relieve the family of this onerous duty.

The stigma associated with mental illness has, in the past, led families to want to hide away the "defective" members of their clan and has resulted in the abuse of the health care system to accomplish this end. While it is hoped that such practices have been effectively curbed by the safeguards that now exist in the system, it must be assumed that these tendencies persist. Family members may not act in the "best interests" of the client but in their own interest. Concerns about family practices may affect decisions made about treatment and record disclosure. The difficulty in monitoring the decisions of substitute decision makers and other related concerns was explored in the Psychiatric Patient Advocate Office submission⁶⁵ and is also mentioned in other submissions.⁶⁶

Doctors and psychiatrists have accepted a fiduciary or trust relationship as the basis of their dealings with clients and their adoption of a paternalistic

⁶³ Supra, quoted a psychiatrist's comments noting the "many indirect or hidden costs of the advocacy program" that "we can't spend time with patients if we are with lawyers and Review Boards. We're so busy defending what we do, we can't do it any more".

⁶⁴ In many respects this conflict parallels that which exists between the life and remainder interests in an estate under a trust.

⁶⁵ Psychiatric Patient Advocate Office, "Submission to Weisstub Inquiry on Competency Determination", May 1989 at 29-32.

⁶⁶ For example, see Angela Browne, "Submission to the Enquiry on Mental Competency", April 7, 1989.

approach is supported by their education and the respect that has been accorded their position in society. This version of the status quo has, however, been challenged from both inside⁶⁷ and outside⁶⁸ the profession, and with the ascent of individual autonomy rights the basis of the relationship has been seen to move in the direction of contractualism. The direction of these changes is reflected in the Canadian Psychiatric Association Position Paper which noted:⁶⁹

Pervading all mental health legislative reform has been the move to

- 1) limit the restriction on the mentally ill and
- 2) transfer the authority from the psychiatrist to the legal profession and the Court.

When viewed at arm's length, the nature of medical training,⁷⁰ financial incentives⁷¹ and the intensive marketing of drugs⁷² and other technology by commercial concerns all serve to create systemic biases in favour of intervention. In the absence of countervailing forces, these biases will tend to give rise to the over-medication of patients.⁷³ In order to expand the scope of its power, the

⁶⁷ In particular, see the work of Thomas Szasz and R.D. Laing and the development of the "labelling" theory of psychiatric illness.

⁶⁸ There are now numerous groups supporting the rights of psychiatric clients to refuse psychiatric interventions (for example see "Peer Advocate - A Voice of Former Psychiatric Inmates & Survivors of the Neuropsychiatric System", April 1989). See also Ontario Progressive Conservative Party, "Patients' Rights - Building a More Balanced System (Discussion Paper)", December 1986 at 15 documenting a number of "therapeutic misadventures" as evidence of "serious systemic abuse".

⁶⁹ Canadian Psychiatric Association, "Financial and Personal Competence in the Elderly - Final Draft - Canadian Psychiatric Association Position Paper" at 2.

⁷⁰ This includes the honest and reasonable belief that they know more about the problem than the patient, and are better able to make decisions with respect to it, and also that the intervention that they are suggesting may help.

⁷¹ The "fee for service" system provides systemic financial encouragement of the over-supply of psychiatric and medical and as documented in the Wall Street Journal article of March 1, 1989, the usage of medical services such as lab testing by doctors is closely related to the existence of financial incentives encouraging the ordering of such work.

⁷² The multi-billion dollar drug industry's efforts to encourage doctors to prescribe their wares are nothing short of legendary. While the most ethically offensive practices of giving lavish gifts to doctors are now discouraged, the continuing sponsorship and support of research, conferences, handouts and other promotional efforts continue. For example see the Valium promotional material reprinted in "Peer Advocate - A Voice of Former Psychiatric Inmates & Survivors of the Neuropsychiatric System", April 1989.

⁷³ As was found to have been involved in the deaths of a number of patients as cited in Ontario Progressive Conservative Party, "Patients' Rights - Building a More Balanced System (Discussion Paper)", December 1986 at 15. This paper proposed the adoption of a "Patients' Bill of Rights" and the introduction of new "Health Care Complaints Commission" to supplement the existing self-regulating Health Disciplines Colleges.

medical profession may be expected to promote the use of a discretionary approach to capacity assessment.

While the role of commercial suppliers of drugs and other such products and services in treatment decisions should be insignificant, it would be naive to assume that their extensive marketing efforts have no effect on the professionals that have the power to prescribe or recommend the use of their products. It would therefore be wise to assume that said suppliers have tended to bias the medical system in favour of the use (or overuse) of their products.

C. THE PARTIES AND INTERESTS - SUMMARY

The full range of social concerns and motivations that may influence affected parties should be considered when establishing the methods for the assessment of capacity. Such analysis will allow inherent tendencies to be countered with appropriate checks and balances in either the substance or the procedure of the test.

The interests discussed above may be assumed to motivate the actions of at least some of the parties that may be involved in the assessment of capacity. While it is impossible to fully anticipate and/or eliminate the influence of such underlying factors, it is desirable that the assessment methods be designed in light of the possible impact of these interests. In this regard, a balance must be struck between giving assessors overly wide discretion which could result in abuse, and the over-legalization of the process which carries with it many adverse implications.

VI. THE ALLOCATION OF UNCERTAINTY AND THE ROLE OF TESTING

A. TESTING AND THE ALLOCATION OF UNCERTAINTY

Uncertainty tends to be a pervasive element in the assessment of marginal decision making capacity. The hypothetical nature of the competency construct and the combination of social and psychological factors all join to increase the level of uncertainty associated with the assessment of capacity. The further uncertainties associated with psychiatric diagnoses or psychological testing and the probable outcome of either treatment or other decisions are other elements which may potentially become significant variables in the assessment of capacity.

B. ROLE OF THE TESTING OF DECISION MAKING CAPACITY

The uncertainty associated with the determination of capacity and the outcomes that will result from the selection of one or the other choice, and the practice of relying on the recommendations of expert advisors (in a way that makes them in effect a form of unofficial substitute) gives rise to a number of possible roles for the testing of capacity. These include:

1. Strict Objective Evaluation of an Individual's Capacity

This involves the use of capacity assessment solely to review an individual's functional abilities. The assessment is based exclusively on an objective assessment of functional parameters and excludes consideration of the apparent reasonableness of the choice made by that individual. This would result in a larger number of assessments being made and in more people being found incapable. In many cases the substitute decision maker would come to the same decision as had already been made by the "incompetent" individual. This approach may be questioned for a number of other reasons:

1. The negative impact of labelling an individual incompetent, coupled with the inherent uncertainty associated with such a determination suggests that this finding should not be made unless some incontestable benefit will result from this determination. These concerns suggest that it would not be helpful to find someone incapable and then proceed to substitute the same decision that they would have chosen in any event. The problems that are known to

occur with the use of substitute decision makers⁷⁴ also suggest that unnecessary recourse to this method of decision making should be avoided.

2. It has been suggested in a number of submissions that a sliding scale rather than a strict objective evaluation should be employed in the assessment of capacity. In this regard the OMA suggests that the capacity to trust a doctor to make a decision should be distinguished from capacity to make a treatment decision. It cites Roth in support of the proposition that "there be a loose definition of capacity when the client agrees to treatment with a favourable benefit/harm ratio or disagree(s) to treatment with a poor ratio" and that the "criteria be tightened up, and therefore more clients would be found to be incapable, if the client consented to a treatment that had a poor benefit/harm ratio or refused treatment with a highly favourable ratio".⁷⁵

2. Promotion of "Best Interests" Decision

The promotion of a "best interests" decision is consistent with the belief that the uncertainty associated with the determination of capacity is greater than that associated with the identification of the individual's best interests by the authorities. A sliding scale approach could be implemented in a number of different ways. The informal tendency in present practice is to utilize the outcome considerations (that give rise to the sliding scale) as a form of threshold⁷⁶ test, thus exempting persons whose decisions conform to the expectations of those around them from review. Other alternatives would set a lower threshold for a capacity assessment and/or would use the outcome considerations as factors in the context of a formal assessment. This approach assumes that the individual's "best interests" can be objectively and unambiguously determined and that those in authority can and will act in this idealized fashion. However, both the previously enumerated concerns and actual practice⁷⁷ suggest that such decisions should be independently reviewed

⁷⁴ See Psychiatric Patient Advocate Office, "Submission to Weisstub Inquiry on Competency Determination", May 1989 at 29-31.

⁷⁵ Ontario Medical Association, "Ontario Medical Association Submission to the Weisstub Enquiry on Mental Competency", May 1989 at 3.

⁷⁶ In the context of this report the word "threshold" refers to the level of evidence of incapacity that must be demonstrated before an assessment should be ordered.

⁷⁷ See in particular Ontario Progressive Conservative Party, "Patients' Rights - Building a More Balanced System (Discussion Paper)", December 1986, "Peer Advocate - A Voice of Former Psychiatric Inmates & Survivors of the Neuropsychiatric System", April 1989, and Psychiatric Patient Advocate Office, "Submission to Weisstub Inquiry on Competency Determination", May 1989 for three different perspectives on the need for

and therefore that all decisions made by or on behalf of incapable patients should be made the subject of review by a substitute, Review Board or similar body.

3. Evaluation of "Best Interests" Decision

The use of capacity assessments to review the best interests recommendations of medical and other advisors raises a number of questions with implications going beyond the scope of the Enquiry mandate, among these being that:

1. Given many patients' reliance on the fiduciary relationship that exists between doctors and patients, and their unquestioning acceptance of medical recommendations, does it make sense that only the treatment decisions of incapable patients be made the subject of special review procedures?⁷⁸
2. Changes that move medical and psychiatric care away from a relationship under which the care giver feels a paternalistic, fiduciary duty to act in the best interests of the patient, to a more contractually based model may negatively impact the quality of care and the duties of the care giver with respect to the patient.
3. Legal treatment requirements will interfere with the ethical treatment of patients and place doctors in the impossible position of being unable to simultaneously meet both the legal and ethical rules under which they are bound to operate.⁷⁹

independent review.

⁷⁸ The questionable basis of this distinction is clearly expressed in Ontario Medical Association, "Ontario Medical Association Submission to the Weisstub Enquiry on Mental Competency", May 1989 which at 2 notes "in the clinical world with pain and suffering virtually every patient who has some pain, fear, depression or anger, which may or may not be accompanied by cerebral dysfunction, will have some lessened ability to respond with all of the cognitive and emotional strengths that they might have had if they were not ill or suffering in some way. ... In a common clinical situation, a patient may have an impaired ability to understand the issues relating to diagnoses and treatment and yet be able to trust their physician to give the best possible treatment."

⁷⁹ For a discussion of response of psychiatrists to the increased administrative and procedural requirements set out in the *Mental Health Act* see Manson, "Advocacy in Psychiatric Hospitals - Evaluation of the Psychiatric Patient Advocate Office", 1987.

See also Ontario Medical Association, "Ontario Medical Association Submission to the Weisstub Enquiry on Mental Competency", May 1989 at 4 noting that to be told by the law not to "treat the incompetent patient when the physician knows that he has a treatment that can alleviate suffering, prolong life and more rapidly

C. THE ROLE OF TESTING - SUMMARY

Testing of decisional capacity can be used to further a number of different objectives and while it might seem desirable to use testing only to protect dissenting individuals from the adverse consequences of incapable decisions, this approach requires that reliable systems exist to ensure that incapable but consenting individuals are protected from possible abuse, overdrugging, etc. The present practice employs testing primarily in those cases where the individual and another party (often a doctor in the medical context) disagree. This practice has, however, been questioned by patient rights groups and other concerned parties. The alternative of employing testing in all cases would result in a greater number of assessments and would implicitly be using the assessment process as a method of reviewing the quality of informally made substituted decisions made by physicians. The present approach can be defended on the basis that it respects the choice made by the individual and avoids stigmatizing an individual with the label of incompetency when the individual has made a choice and informally delegated the decision to a trusted care giver. Conceptually this approach is consistent with the belief that uncertainty with respect to detecting incapacity is greater than that with assessing the desirability of the outcome. The use, on the other hand, of testing of decisional capacity in all doubtful cases accommodates a larger measure of uncertainty with respect to outcome and allows an official substitute decision process to be employed as a way of reviewing the correctness of the recommended decision.

The principle to be favoured in the assessment of capacity is that of furthering individual autonomy. For this reason, and in light of the uncertainty associated with the determination of capacity, we generally favour restricting assessments to those individuals whose behaviour has given rise to a strong suspicion of incapacity. However, in situations in which the individual may be particularly susceptible to institutional coercion, we favour more comprehensive testing of capacity so as to protect incapable consenters.

allow a patient to live a productive life in the community" is to "compete with the ethical tenets of medicine."

VII. BASES FOR ASSESSING DECISION MAKING CAPACITY

The Enquiry has identified three fundamental bases for assessing and identifying one's decisional capacity: function, status and outcome. Together, these categories set the boundaries within which capacity may be assessed.

A. FUNCTION

Tests of function assess the individual's decision making skills and may be administered in a number of different contexts, using different approaches, methods and standards. While a test of function is theoretically distinct from a test of outcome, in practice the difficulty of separating the assumptions which underlie tests of rationality from those which underlie tests for a reasonable outcome cause the tests to merge at the margin.

The present Ontario *Mental Health Act* and most commentators have adopted a form of functional test, although it is arguable that the requirement for "appreciation" injects some measure of consideration of the outcome, as it seems closely connected to a recognition of a reasonable outcome. Furthermore, the differences between the competency criteria in the *Mental Health Act* and those in the *Mental Incompetency Act* and the requirement for mandatory assessment of capacity to manage an estate that is prescribed for psychiatric patients under the *Mental Health Act*, suggest that a person's status as a psychiatric patient may be considered a factor in this latter test of capacity.

B. STATUS

Status refers to those elements of the individual's or the situation's status such as the person's age, mental diagnosis, psychiatric status, consciousness, etc., the complexity of the decision at issue, the importance of the subject matter to the decision maker, etc., either as individual determinants (in the case of the individual) or in combination with one another (in the case of individual and situational parameters). In practice, while the use of status violates the fundamental precepts of equal treatment and due process protections, there may be practical social concerns that justify reference to such status based parameters as age (in the case of young children), and in some situations (such as those involving unconsciousness) the status will be coincident with such profound incapacity as to effectively preempt further testing.

C. OUTCOME

Outcome tests the probable outcome against that which would be preferred by a reasonable person. It therefore tends to reflect assumptions about the consensual view of those making the assessment. The use of outcome as a factor requires that the validity and accuracy of the assessment of the outcome should be considered and evaluated separately.

The use of outcome presents a number of conceptual and practical problems. These include the difficulty of avoiding the violation of individuals' autonomy through the imposition of a "reasonable person" standard on individuals. Our pluralistic society grants, and must respect, the individual's right to act "unreasonably" and to make foolish decisions should they choose. The distinction of the intended from the probable outcome is another variable that must be considered and adds to the complexity of the determination which must be made, should it be decided that outcome is to be included as a factor.⁸⁰ For these reasons the use of this parameter should be limited and qualified in light of the above concerns.

D. AIMS OF CAPACITY DETERMINATION

The aim of testing decisional capacity is to evaluate the functionality of an individual's capacity to make a given decision in a manner that reflects the concerns discussed in the previous section. It is a further aim that such testing will enhance, rather than diminish, the abilities of the individual in question; this aim includes the identification and treatment of all treatable deficiencies to facilitate the recovery of capacity.

The desirability of allowing individuals to exercise the greatest possible measure of control of their lives demands that tests of decisional capacity accurately reflect the requirements of the particular decision. Testing must therefore facilitate weighing the parameters, whether these be cognitive or social factors that indicate decision making capacity in a manner that limits the discretionary component and the possibility of inconsistent and unequal treatment. The assessment process must also, reflect social decisions with respect to the interests and principles to be favoured in the process.

⁸⁰ In this regard it may be noted that our society and law is generally less protective of an individual's right to achieve an undesirable result as a result of a mistake, than by intentional choice.

E. BASES OF ASSESSMENT - SUMMARY

The basis of capacity assessment must be the measurement of the functional abilities of the individual. Although it may prove desirable to allow some status or outcome considerations to be employed in the assessment process, such practices must reflect either improved means of evaluating function⁸¹ or else a clearly enunciated policy decision.⁸²

⁸¹ Such could be the case where the factor was closely causally related to the functional characteristic in question and could therefore provide a more accurate means of measurement than could other approaches.

⁸² For example given the empirically demonstrated stages of cognitive development of children, the desire to avoid subjecting children to assessment procedures, and the legal duty imposed on parents or substitute guardians it seems reasonable and we recommend that a young child's age should be considered as a factor.

VIII. PROCEDURAL CONCERNS

A. PRESUMPTION OF COMPETENCY

The preeminence of liberty and individual rights has given rise to a common law presumption of competency. This presumption prevails in uncertain cases unless it is shown that an individual is incompetent. While in general, an individual's status should not affect this presumption it is, however, presently either rebutted⁶³ or reversed⁶⁴ by statute with respect to minors.⁶⁵ Some physicians concerned about the plight of chronically disordered persons, and a number of the families of schizophrenics, suggest that certain psychiatric diagnoses should also be taken as either weakening or rebutting the presumption. On the other hand, those advocating greater patients rights, while supporting the presumption in principle, would like to see some mechanism put in place to protect such persons. They note that in practice, an individual's agreement with the recommendations of the authorities tends to ensure that the presumption will not be challenged, whereas a disagreement is likely to call into question the individual's capacity.

B. BURDEN OF PROOF

The allocation of the burden of proof should reflect the presumption of competence, the practical difficulties that would be imposed on the party carrying the burden and other logistical concerns.

The presumption of competence obviously places the initial burden of proof on the party alleging incapacity. While the ongoing burden is generally thought to remain with this party, and in the medical consent context it would appear to rest on the psychiatrist or doctor who was disputing the capacity of the patient,⁶⁶ the case law with respect to testamentary capacity requires only that the party contesting capacity bring capacity into doubt. Having done so, the burden of proof shifts to the party propounding the will to demonstrate the capacity of the testator.⁶⁷ This anomaly would appear to be limited to questions of testamentary

⁶³ Ontario, *Public Hospitals Act*, O. Reg. 518/80, s.23.

⁶⁴ Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended), s.1d.

⁶⁵ More specifically in both Acts those under the age of sixteen.

⁶⁶ Psychiatric Patient Advocate Office, "Submission to Wessman Inquiry on Competency Determination", May 1989 at 35 and 36 notes that in the psychiatric context that the burden of proof remains on the physician.

⁶⁷ *Alberia v. Cushman* (1987), [1987] A.J. No. 1120 (Q.B.) at 2 cited *Leger and Michaud v. Poirier* (1944), [1944] S.C.R. 152 at 164 to support the decision that since "testamentary capacity ... has been called into

capacity and as this is a burden imposed by the law of wills, it is not germane to the tests of capacity that are the subject of this report.

Disregarding this anomaly, the burden of proving incapacity rests on the party asserting same, unless a convincing rationale for its being shifted is presented.

C. STANDARD OF PROOF

The selection of the standard of proof requires the balancing of the damage done through inappropriate deprivations of autonomy (false positives) against that done by allowing incapable individuals to make decisions contrary to their own best interests (false negatives). However, it should be noted that the question of the standard of proof is so intimately tied to that of the substantive test as to have little meaning when considered in isolation.

Notwithstanding that caveat, given the balancing nature of the decision and the ability to protect autonomy in the substantive content of the test, the use of the civil standard of the balance of probabilities would appear to be preferable. This standard is more clearly defined, and is consistent with the nature of the interests balanced under the test, and case law on this subject.⁸⁰ The proposal that the criminal law "beyond a reasonable doubt" standard be adopted, as was suggested by Fram,⁸¹ as the standard for both capacity to manage property⁸² and to care for the person,⁸³ referred to the *Mental Incompetency Act* but did not address the distinction between proceedings brought by application under s.7 (affidavit evidence

question, the onus rests on the defendants, as the ones propounding the will, to affirm positively the testamentary capacity". For further discussion of the *Leger and Michaud v. Poirier* case, see Appendix V.

⁸⁰ For example in the testamentary capacity case *Alberta v. Dickson* (1986), [1986] A.J. No. 551 (Q.B.) at 2 *O'Neil v. The Royal Trust Company of Canada* (1946), [1946] S.C.R. 622 at 632 was cited to support the rule that "Testamentary capacity is a question of fact determined on the balance of probabilities." and in *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 (Dist. Ct.) it was noted that while "the effect of a finding of mental incompetence against Justin Clarke no doubt imposes upon him some measure of restriction, this is a civil and not a criminal court, and the guiding principle of the whole jurisdiction is what is most for the benefit of the unhappy subject of the application". In this case it was also noted that the "Mental Incompetency Act is designed to protect those persons who by reason of arrested or incomplete development of the mind need protection. Its purpose is not to detain needlessly or to imprison." For further discussion of the *Clarke v. Clarke* case, see Appendix II and Appendix V.

⁸¹ Fram, "Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons", 1987.

⁸² *Supra*, Draft Act s.19(3).

⁸³ *Supra*, Draft Act s.54(2).

only) and those tried under s.8. This distinction was the basis of the decision in *Clarke* that the higher standard of proof was only required in the case of applications and was not therefore the correct standard to apply at trial. Thus, while the "beyond a reasonable doubt" standard could be used to protect individuals while facilitating inexpensive judicial determinations by affidavit application, it should not be used as the standard in those cases in which a hearing is held.

D. PROCEDURAL SAFEGUARDS AND PROCESSES

Variations in the expected duration of an individual's incapacity and in the extent and consequences of incapacity suggest that different procedures be employed in different contexts. In this regard it would be desirable to provide both full "due process" and abbreviated versions of the procedure for decision making capacity determination. Hence, decisions must be made with respect to:

1. The choice of the assessor, individual or tribunal
2. Notice to the individual and right to participate
3. Rights advice and right to counsel
4. Right of appeal including appeal to court, and
5. The time period between reviews.

Our recommendations with respect to the above factors will be considered as part of the discussion of the proposed criteria which are set out later in this report.

E. PROCEDURAL CONCERNS - SUMMARY

Subject to a few exceptions, the presumption of competency is the default from which deviation must be shown. The burden of proof lies on the party asserting incapacity, and the standard of proof is on a balance of probabilities. Other procedural concerns including the choice of the assessor, the form of notice to the individual, the provision of rights advice and counsel, the maximum period between reviews and the availability of appeal options depend on the context in which the assessment is taking place and must balance the principles and concerns enumerated in the previous sections of this report. These issues will be addressed in the discussion of proposed criteria which appear later in this report.

IX. DIFFERENT METHODOLOGICAL APPROACHES

Testing for decision making capacity involves assessing the individual's functionality in terms of the demands of the decision to be made. In situations involving unrelated, single event decisions the preferred approach is to test the individual in a manner that accurately reflects the demands of the actual decision. In other circumstances, such as those involving decision making capacity to care for self or property, it would be more useful if the assessment could be performed in two stages; firstly, as a test of the individual's ability with respect to the type of decision to be made and secondly, as an assessment of the requirements of the particular situation for which the capacity is required. Conceptually there are three distinct approaches that may be followed in this regard.

A. THE ASSESSMENT OF THE INDIVIDUAL ALONE

Under this approach, the individual's reasoning abilities would be tested with respect to either abstract or factually unrelated matters. This approach has been criticized in that it fails to test the individual's appreciation of the particular situation.⁹² Its main advantages lie in its avoidance of an assessment of an individual's social competency, the efficiency benefits of standardized testing, and the possible applicability of the results of a single test to a number of different decision making situations.

However, this approach seems to be too crudely calibrated to satisfy the requirements for fair and accurate testing of marginal competency insofar as it fails to take into account the manner in which capacity interacts with the context in which it is to be exercised, or the specific requirements of a given decision. The primacy accorded individual rights, coupled with our recognition of the marginal nature of the competency construct, suggests that except in the clearest cases of global incapacity, before an individual is declared incapable an effort must be made to more accurately assess the individual in light of the specific decisional context.

B. THE ASSESSMENT OF THE PERSON IN THE CONTEXT

Under this approach individuals are tested in the decisional context, thereby allowing their response to the specific situation to be concretely assessed. Use of this approach allows both actual understanding and appreciation to be assessed, but is limited insofar as the results apply only to the particular situation. Furthermore,

⁹² As the best this form of assessment tests an ability to understand and possibly ability to appreciate, it cannot however test either actual understanding or appreciation.

implementation of this approach is logistically difficult as it requires either simulation of the context, or the introduction of the assessors into the actual environment. These limitations can make it relatively expensive. But despite these concerns, it is probably the approach that should be used in most cases, and especially in those cases involving a discrete decision of some importance to the decision maker.

C. TESTING THE PERSON AND CONTEXT SEPARATELY

This approach involves two separate assessments. Firstly, relevant elements of an individual's decisional capacities are assessed, and secondly, the contextual requirements of a valid decision are measured. The results of these two assessments are then compared to obtain a measure of the individual's capacity to make the decision in question. This approach allows both the person and the task to be considered but is more efficient insofar as the capabilities demonstrated during the individual's assessment would be scaled against the requirements of a particular decision in order to determine whether or not the individual has the capacity to make that decision. Such assessments would be made as follows:

Firstly, an assessment would be made of the individual's capabilities with respect to the type of decision. This test would measure the individual's functional abilities with respect to cognition, reasoning and other relevant skills.

Secondly, the requirements for an individual to be considered capable to make the particular decision would be determined. This standard would reflect parameters such as the importance of the decision, the nature of the alternative outcomes, the certainty of the outcomes, etc.

The assessments of the individual and of the decisional context would then be compared to determine whether or not the individual had the capacity to make the decision.⁹³ To improve the accuracy of an assessment, individuals could be tested in a manner tailored to the requirements of decisions of a specific sort. Thus an individual could, for example, be tested for capacity to make treatment decisions, financial decisions, to request disclosure of medical records, etc. and when they were faced with such a decision, their capacity rating (in relation to the

⁹³ This presupposes the use of a test instrument which would give rise to meaningful numeric indices of an individual's cognitive capacities, relevant social knowledge, rational thinking abilities, etc. It is hoped that the research work presently under way in Canada and the U.S. such as that presently taking place at the Baycrest Competency Clinic may give rise to such instruments in the near future.

area of interest) would be compared to the minimal standard for those type of decisions. On this basis, an assessment would be made as to whether or not the individual had the capacity to make the decision at issue.

D. METHODOLOGICAL APPROACHES - SUMMARY

It would appear that the best approach to assessment involves the testing of the individual in the decisional context. In the future it may become possible to more accurately quantify the parameters of decisional capacity in a way that would allow the individual and the context to be assessed separately and then compared but this course cannot be recommended at the present time.

X. ISSUES TO BE CONSIDERED IN THE ASSESSMENT OF CAPACITY

A. SCOPE OF DECISIONAL CAPACITY DETERMINATION

1. Scope of Decisions Affected by Determination

The extent to which a finding of capacity or incapacity made with respect to one decision or type of decision applies to other decisions should be determined primarily by the probability that a different conclusion would be reached were the assessment repeated for the new situation. This reflects both the variability of the individual's capacity and the differing requirements of different decisions. Such evaluation should also consider the significance of the difference which may be found to exist and the inconvenience and cost of repeating the test. The limits to the scope of marginal competency should be established on the basis of the functional requirements of the decisions at issue, with due consideration of the factors mentioned above.

2. Duration of Validity of Determinations

The second limitation on the scope of a decision making capacity determination concerns the time period for which the determination will be valid. The selection of this time period should reflect the probability that there will be changes in the individual's capacity. The distinction must be made between individuals for whom incapacity is a continuing condition and those for whom it is likely to be a short term or variable one. Mandatory review on an annual basis for chronic long term conditions, or every three months for short term cases, with the option of earlier reviews in the event of a change in condition, would appear to be reasonable minimum. Earlier formal reviews should be made upon detection of change by a care giver. Alternatively, a review in the form of a screening test should be made available to the decision maker on request. Rapidly changing capacity may require multiple tests in order to facilitate assessment of both the level and variability of the individual's capacity. In cases of rapidly fluctuating capacity the most appropriate format involves testing the individual as closely as possible to the time when the decision is to be made.

B. SCOPE OF CAPACITY DETERMINATION - SUMMARY

The limits on the validity of a capacity assessment must be defined in terms of both subject matter and time. In order to make marginal capacity a meaningful concept it is necessary to carefully limit the scope of the validity of a determination

of capacity in terms of subject matter to which the determination would apply. Mandatory annual review in the case of chronic conditions, and after three months for acute conditions, are the recommended maximums, with the provision being made for earlier reviews at the request of either a care giver or the decision maker.

C. FACTORS THAT MAY BE CONSIDERED IN DETERMINATION

The considerations discussed previously, and a review of the literature, suggest a number of different parameters which may be included in tests of decision making capacity.

1. Tests of Individual's Functional Mental Ability

Clinical tests of decisional functioning have been extensively discussed in the literature by Appelbaum, Grisso, Roth and others, and a variety of instruments have been reviewed in the recent book on evaluating decision making capacity by Grisso.⁹⁴ This report will consider a number of these instruments in the section discussing the proposed tests. Other parameters which may assist in the assessment of an individual's capacities include the following:

a. Evidence of Poor or Changing Decision Making Practices

Proof of socially unacceptable decision making practices, as evidenced for instance by actions found to justify involuntary commitment, may be relevant to the determination of incapacity. Nonetheless, use of such information is problematic because of its prejudicial nature. The distinction between social incapacity, a refusal to make decisions in accordance with social rules and norms, and mental incapacity is often hard to discern and serves to highlight the requirement that testing should focus on functional parameters. These considerations and the principles favouring individual autonomy require, therefore, that involuntary commitment or similar evidence of poor decision making practices not be used as a parameter. This suggestion does not, however, preclude consideration of the evidence of behaviour that led to the earlier determination, but requires that the capacity assessment must be performed on its own terms and on its merits.

⁹⁴ T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

A number of the submissions received by the Enquiry discussed the interface between capacity and commitment and in particular the problems posed by the committed but capable patient. Although the subject of committal is clearly outside the mandate of the Enquiry and will not be discussed herein, the numerous submissions we received on this subject and the statistically significant correlation between committal and incapacity lead us to observe that this topic would appear to be deserving of further consideration.

Evidence of an unexplained change in decisional practices seems intuitively less prejudicial and may help to corroborate or confirm a change in the capabilities of the individual. For this reason clear and unambiguous evidence of such changes may be considered during an assessment.

b. Diagnoses of Particular Symptoms

The existence of a diagnosis which would support and explain an incapacity is another element in the assessment of decision making capacity, the use of which is controversial. It is recognized that the correlation between the extent of organic or other medically measurable defects and loss of functionality is not high and therefore may be more prejudicial than probative of capacity. Another problem arises out of the normative characteristics of many diagnostic procedures and the manner in which personality characteristics may be labelled as pathological. Notwithstanding these concerns, the existence of an objectively corroborated physical diagnosis that helps to explain unambiguously pathological behaviour should be taken into account.

c. Change in Behavioral Patterns

A substantial and unexplained change in an individual's approach to the making of decisions might corroborate that a diagnosed condition affected the individual's capacity. Conversely, the fact that an individual has not displayed a change in personality or decisional patterns would refute the possible inference that a diagnosed condition had caused an impairment of the individual's capacity. While this should not imply that individuals may not change their minds or patterns of behaviour without being seen as ill, it can be helpful when assessing members of the geriatric population who have developed sedimented preferences and patterns of behaviour.

2. The Use of Sliding Scales to Change the Test

The input from the Advisory Committee and the submissions received by the Enquiry have highlighted a significant difference between the medical and legal approaches to this question. The medical paradigm holds the view that there is a process of restoration which is achieved through diagnosis and treatment. The legal approach expresses its caution about the efficacy and primacy of treatment against the measurement of other social values through its use of procedures and checks and balances. For this reason the use of sliding scales, which vary clinical test parameters with reference to outcome, appear to be more consistent with the clinical process. Those in favour of the use of sliding scales suggest that having flexible test standards may allow a reduced level of intervention and a rational allocation of economic resources. It should be noted, however, that there are two different meanings that have been ascribed to the sliding scale concept and have been a source of some confusion in this regard.

The first, which we will refer to as a "contextual" sliding scale, varies the difficulty of the test depending on the nature of the question to be decided. This form of sliding scale refers to parameters such as the importance of the subject matter of the decision to the decision maker, but does not refer to the choice that the decision maker has made. The contextual sliding scale is not incompatible with the requirements for impartiality of procedural due process, and is consistent with the assessment of capacity as a marginal construct.

The second meaning, which we will refer to as an "outcome" sliding scale, varies the difficulty of the test of capacity depending on the choice made by the individual and more particularly on the expected outcome of that choice. The use of an outcome sliding scale is criticized for its tendency to allow authorities to enforce conformity with their view of what is the correct choice that should be made in any given situation, and for the infringements on individual liberty that this produces.

The following are considerations which could be employed as factors in one or other form of sliding scale:

a. Complexity of Information and Decision

The complexity of the information that should be weighed in the course of coming to a reasoned decision is a factor which will usually be relevant to the determination of whether or not the individual possesses sufficient mental capacity

to make the particular decision. The inclusion of complexity as a parameter in a contextual sliding scale is generally accepted and uncontroversial. The parameters of complexity depend on the decisional context, but will typically include considerations such as the number of factors that must be weighed, the nature of the relationships between these variables, the number of options, and the complexity of the consequences that will result from the selection of any given option.

b. The Nature of Alternative Choices

The existence of alternative choices and the nature and complexity of the alternatives and the comparison of them are important elements which should be considered when assessing the complexity of the information which needs to be considered by the decision maker.

c. Importance of Decision to Decision Maker

The importance of the decision to the decision maker may be divided into two sub-issues. The first, namely the general significance to the individual of the decision in question, is compatible with its use in a contextual sliding scale while the second, which includes consideration of the outcome that will predictably result from the choice, can only be included in an outcome sliding scale. As noted above, the use of the outcome as a factor is more controversial. It results in the individual being required to prove a higher level of decision making capacity to make a decision with adverse consequences than one with a favourable benefit/harm ratio.

The consideration of the importance of the decision in a contextual sliding scale can help to enhance individual autonomy by allowing individuals to make decisions of minimal significance without interference. In this sense it could serve as a component in a threshold test, in addition to being a factor in the actual assessment of decisional capacity.

d. Reversibility of Consequences of Decision

The reversibility of the decision is a factor in the assessment of the importance of the decision to the decision maker. Reversible decisions are generally of less importance than those giving rise to irreversible consequences.

e. Certainty of Outcome

The certainty of the impact of an outcome is a factor which should be weighed in considering the outcome itself. Given our bias in favour of allowing individuals to make their own choices, the existence of a large measure of uncertainty supports use of a less stringent test of capacity. Under these circumstances, the wishes of the individual should be respected, as their choice may be as valid as that of a substitute.

f. Importance of Decision to Others

Determinations of decision making capacity can have a profound effect on those that are involved with the individual in question. Although the legal *parens patriae* model excludes consideration of the effect on others, arguments can be made that a broader social perspective should include some consideration of such impacts. On balance, however, the potential abuse of considerations based on the impact of an individual's decisions on others and the primacy accorded individual liberties suggest that such concerns should be accorded minimal weight at most.

g. Substitute Decision Making Procedures

The availability and form of formal and informal substitute decision making provisions are potentially relevant in two ways.

Firstly, with respect to the formal substitute decision making process: A proper balancing of the interests implicated in the determination of decision making capacity must reflect the consequences of a finding of incapacity. These include the manner in which the decision in question will be made, and the best interests model that will provide the basis of the decision. Before an individual is to be adjudged incapable and deprived of the power to make decisions, it is important that the substitute decision making scheme represent a significant improvement over allowing the individual to make that same decision, that it serve to minimize constriction of the individual's liberties and autonomy, take his or her views (past and present) into account and provide procedural safeguards that allow abusive situations to be detected and remedied. Deficiencies in the substitute decision making scheme would justify lowering the requirements for an individual to be found capable so as to allow more individuals in doubtful cases to make their own decisions.

Secondly, with respect to informal substitute decision making schemes: the suggestion has been made that in a number of contexts it is unreasonable to require that individuals be capable to make complex decisions which involve special technical knowledge or expertise. These types of decisions are typically made by individuals with the assistance of experts. More specifically, the OMA submission to the Enquiry suggests that in the treatment context, patients need not be capable to make a decision regarding the treatment, provided that they are capable of trusting the doctor or psychiatrist to administer appropriate treatment.⁹⁵ This effectively serves to replace the requirement for the decision making capacity to make the "decision" with that needed to either delegate a power or to appoint a substitute to make the decision. This issue requires reference to the earlier discussion of the underlying objectives of capacity assessment and, as was noted in that section, we have generally recommended that this question be resolved in favour of respecting an individual's choice, absent the possibility of institutional coercion.

h. Avoidance of Bias

In the past, decision making capacity assessment procedures have been criticized as being biased in favour of certain racial, linguistic, cultural, gender, or age groups. In this regard, every effort must be made to ensure that the language of the criteria and tests are as simple and neutral as possible. In addition, the procedures employed should be sensitive to differences and should attempt to maximize the comfort and performance of individuals on the tests. This requirement may involve testing individuals in their homes, delegating some of the assessment work to individuals that are more compatible with the subject, and in other ways reducing the potential impact of such differences. Given the difficulties that are implied by the cross-cultural testing of decisional capacity, it would appear that in the absence of mitigating factors (such as the use of an individual of the same group for the testing) the uncertainty that this introduces should result in a lowering of the requirements for an individual to be found capable of making any decisions in which cultural differences are potentially a factor.

⁹⁵ Comparable arguments can obviously be made on behalf of lawyers, accountants or other professionals but the given the focus of the Enquiry, the medical and psychiatric issues are obviously of more immediate relevance.

D. FACTORS THAT MAY BE CONSIDERED IN CAPACITY DETERMINATION - SUMMARY

The above are some of the factors which will be weighed in the course of assessing the capacity of the individual. The primary factors are those related to the functional abilities of the individual. Other evidence pertaining to the individual -- including that of changing decisional practices and clinical diagnoses, must at most be accorded secondary importance. The use of situational parameters depends very much on the nature of the decision for which the assessment is being made and will vary from context to context. In general, however, increasing complexity of information and level of significance of the decision will increase the requirement for capacity. Decreasing importance and increasing uncertainty with respect to outcome serve to reduce the requirements, and below a certain *de minimus* level, should allow the individual's wishes to prevail unchallenged.

E. THE CONTEXTS OF THE TESTS OF MENTAL DECISION MAKING CAPACITY

1. Capacity to Make Decisions on Treatment and Experimentation

Capacity to make decisions in the treatment context is a necessary but not sufficient condition for informed consent. Although the *Mental Health Act* does not explicitly define informed consent, a recently proposed Connecticut statute, the *Act Concerning Patients' Rights*, defines informed consent in accordance with generally accepted definitions as follows: "Informed consent means permission given voluntarily on the basis of **knowledge** and **understanding** of the implications, consequences, possible complications, effects of such permission, medically acceptable alternatives and risks of no treatment".⁹⁶ The parameters of informed consent are generally recognized as being the requirement for **materiality**, **voluntariness** and **competency**.⁹⁷

⁹⁶ Cited in "Testimony of the Office of Protection and Advocacy for Handicapped and Developmentally Disabled Persons Before the Judiciary Committee on 'An Act Concerning Patients Rights' reprinted in "Peer Advocate - A Voice of Former Psychiatric Inmates & Survivors of the Neuropsychiatric System", April 1989.

⁹⁷ The leading Canadian case is *Reibl v. Hughes* (1980), [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 14 C.C.L.T. 1 which elaborated on the earlier decision of the same Court in *Hopp v. Lepp* (1980), 13 C.C.L.T. 66, [1980] 4 W.W.R. 645. *Reibl v. Hughes* referred to *Canterbury v. Spence* (1972), 464 F. 2d 772 and adopted the objective patient test that it proposed (albeit with some measure of confusion with respect to the extent to which subjective characteristics of the patient should be considered as elements in the objective test). For further discussion of the *Hopp v. Lepp* case, see Appendix II. For further discussion of the *Canterbury v. Spence* case, see Appendix IV.

Materiality - in this context has two meanings, these being:

1. The accuracy, precision and validity of the data correlating treatment or alternatives and the benefits (physiological effectiveness and clinical effectiveness which includes quality of life implications) and risks. As part of this calculus one is concerned with the probability that the treatment will either produce the desired therapeutic effect, fail to produce the desired effect or worsen the condition being treated. The same analysis needs to be applied to possible side effects.
2. The applicability or relevance to the decision maker (patient) includes an assessment of the importance of the information for the specific decision under consideration. A determination of materiality in this sense would include the decision maker's awareness of the importance of the information to his/her condition. This parameter incorporates such concerns as the urgency of the situation, and the availability of effective alternatives. Other important considerations include: awareness of characteristics of decision makers such as their occupation, interests, hobbies and other such qualities as could be expected to affect an individual's feelings about the outcome.

There are three standards of information disclosure that have been endorsed for informed consent purposes:

1. Professional standard, the amount of information that would be disclosed by an average physician. The problem with this standard is that it is too dependent on medical practice, not sufficiently patient oriented.
2. *Canterbury* case test - objective patient test - what the patient would want to know based on what the reasonable patient would want to be informed of under the circumstances. This is the preferred test for materiality of disclosure.
3. McPherson case test - subjective patient test - what did this particular patient want to know under the circumstances. This standard is too subjective to allow a court to properly review it.

As was mentioned in the note above, the test in Canada, as established in *Reibl v. Hughes*, is basically the *Canterbury* test although tempered by a limited consideration of the subjective characteristics of the patient in question.

In human experimentation one has to be aware of the fact that in some contexts it is not expected that the subjects will obtain therapeutic benefits from the research. However, the requirement for materiality in the second sense would be satisfied if the patient were fully informed that no therapeutic benefit to that person was expected to accrue from the procedure.

Voluntariness is especially relevant in the treatment of vulnerable individuals such as prisoners, the developmentally handicapped and mentally disordered, children and the geriatric population, especially when being treated in an institution. The treatment may be linked to coercive influences such as promises of freedom, increased privileges, remuneration, etc. The issue of voluntariness is also important in human experimentation, especially that which involves vulnerable individuals. Finally, it may also be compromised by the nature of the power imbalances in the doctor/patient relationship and through the exercise of "expert" prerogative.

The context in which the assessment is being performed may also influence capacity to make treatment decisions. Patients institutionalized for long periods of time have been shown to be unusually susceptible to the value systems of the institutions which may subtly or otherwise affect their ability to make autonomous decisions.

The right to refuse treatment is a logical consequence of the requirement for informed consent. Having made sure that the patient is capable, fully informed and acting freely, one can make the logical inference that the subject then has the right to choose to either accept or refuse the recommended treatment.

The factors which may be identified as potentially affecting the manner in which treatment decisions are made include:

- context (where the decision is being made);
- impairments in communication (seeing, hearing, speaking);
- physical or mental pain or stress and undue influence or duress;
- impact of persuasion and the ideology of the presenter;
- psychology of decision making (bias arising out the manner of presentation);
- enhancement of comprehension through direct testing and multiple trials;
- heuristic devices including:
 - representativeness (the tendency of an expert to make a decision about situation A based on similarity to B rather on the information about A);

availability (the tendency to arrive at a concept of probability based on the ease with which an occurrence of a comparable event is seen to occur, same result as representativeness but focuses on the availability of the information about another occurrence);

anchoring (the tendency to perceive experiences as conforming to the expectations of the perceivers).⁸⁸

The law of informed consent proceeds from a series of assumptions about the nature and purpose of human existence which, in their application, support the right of capable individuals to exercise control over their body and their life in a manner that precludes them from being forced to accept unwanted treatment.⁸⁹ These principles are recognized in the common law and under the Ontario *Mental Health Act*, and will be assumed to form the basis of the law in this area. However, while autonomy, independence and free choice are the principles underlying the law, in practice a number of factors serve to impede their full implementation or realization and, therefore, may have a significant impact on the manner in which treatment decisions are made and on the determination of an individual's capacity to make such decisions.

The impact of "total institutions" on their inhabitants, and in particular on the manner in which the patients and inmates of long term care facilities tend to adopt the views of those controlling such institutions, presents a profound challenge to the individual's expression of autonomous decisions. Similarly, an institutionalized individual who is constrained by an acute medical condition may feel less able to express his or her own wishes. These concerns suggest that extra care should be taken when seeking the informed consent of individuals in such contexts.

⁸⁸ As was discussed in the previous section an effort must be made to combat the tendency to diagnose that which one expects to see rather than that which actually exists. See R.E. Kendell "An Important Source of Bias Affecting Ratings Made by Psychiatrists" (1986) 6 *Journal of Psychiatric Research* 135.

⁸⁹ In addition, informed consent and the accompanying provision of information to patients has been found to have positive therapeutic effects without causing the significant elevation in anticipatory fear that had been posited in earlier writings. See D.T. Vernon and D.A. Bugelow "Effect of Information about a Potentially Stressful Situation on Responses to Stress Impact", (1974) 29 *Journal of Personality and Social Psychology* 50 and J.M. Andrews "Recovery from Surgery With and Without Preparatory Instruction for Three Coping Styles", (1970) 15 *Journal of Personality and Social Psychology* 225. These concerns are however peripheral and relatively insignificant when compared with the larger interests in individual autonomy that underlie the legal requirements in this area.

The difficulties arising out of deficiencies in communications, as discussed elsewhere in the report, is most likely to be experienced in individuals in treatment situations and should always be considered and ruled out as a factor in order to avoid inappropriate determinations of incapacity.

The context in which a decision is to be made can influence the capacity of those making the decision. In his study of college educated patients with cancer of the breast, Cassileth demonstrated that the circumstances under which treatment decisions are to be made affect the ability of patients to understand the benefits and risks of available treatments.¹⁰⁰ In this study 200 patients were informed of their diagnosis and provided with information on chemotherapy, radiation therapy and surgery. They signed an informed consent form and the following day were asked to fill out a questionnaire to determine what they understood and remembered about these treatment alternatives. Only 50 per cent understood the nature and purpose of the treatment and approximately 5 per cent were able to identify even one complication. It seemed that only 40 per cent had read the forms carefully.

The ideology of the doctor, as expressed in his diagnostic and therapeutic expectations, has a significant effect on both the assessment of the decision maker and the manner in which the proposed treatment is presented to him or her. However, while the tendency to project one's diagnostic expectations will be discussed in the section on formal assessment and will not be further discussed in this context,¹⁰¹ the presentation of information about the proposed therapy is an important component of informed consent and has significant therapeutic and decisional implications. The therapeutic implications arise out of the placebo effect and the extent to which individual's expectations about treatment are reflected in their recovery or non-recovery.¹⁰² In addition, it has been reported that notwithstanding the safeguards incorporated in single and double blind studies, the expectations of researchers can serve to enhance the "normal" placebo effect and give rise to determinations of even greater therapeutic efficacy. In a study examining the reported efficacy of five failed therapies for angina pectoris, Benson and McCallie found that early single and double blind studies performed by

¹⁰⁰ B. Cassileth, R. Zupkis, and R. Sutton-Smith "Informed Consent - Why are its Goals Imperfectly Realized?" (1980) 202 *New England Journal of Medicine* 696.

¹⁰¹ See R.E. Kendell "An Important Source of Bias Affecting Ratings Made by Psychiatrists". (1966) 6 *Journal of Psychiatric Research* 135.

¹⁰² See T. Silben "Placebo Therapy: The Ethical Dimension". (1979) 242 *Journal of the American Medical Association* 245.

enthusiasts found the therapy to be 70 to 90 per cent effective while later studies performed by more sceptical researchers detected only the normal placebo effect of 30 to 40 per cent efficacy.¹⁰³ The possible therapeutic effects that may result from the care giver presenting an unrealistically optimistic assessment of the benefits of the proposed treatment must be weighed against the legal requirements for informed consent, the scientific underpinnings of our system of medical care and the psychological benefits that are recognized as accruing from fully informing patients about the medical procedure and allowing them to become involved in making decisions about their own treatment.

The way in which decisions are framed and presented by an expert advisor can and does have a great impact on the manner in which individuals choose between alternatives, and brings into question some of our most basic assumptions about the decision making process in general. It is largely assumed that individuals make decisions based on a rational consideration of the implications of one or other course. It is commonly agreed that rationality requires that individuals' choices, at a minimum, reflect consistency and coherence. Research studies have, however, demonstrated that individuals systematically violate the principles of consistency and coherence when making decisions, and have identified a number of psychological principles¹⁰⁴ which should be incorporated into the process of presenting information to the decision maker.¹⁰⁵ A striking illustration of the manner in which the presentation of the information affects choices was seen in the results of experiments carried out with university students. This experiment involved an assumption that a disease was certain to cause 600 deaths if not treated, and presented questions which gave rise to the same effective result but were framed in two different ways. The first frame offered a choice between a certain saving of 200 lives and a one third probability of saving 600 lives. The second frame offered a choice between a certain loss of 400 lives and a one third chance of saving 600 lives. The first choice was adopted by 72 per cent in the first frame but only 22 per cent in the second frame, thus fully 50 per cent of the respondents changed their decision depending solely on whether or not the question

¹⁰³ See H. Benson and D. McCallie Jr. "Angina Pectoris and the Placebo Effect" (1979) 300 *New England Journal of Medicine* 1424.

¹⁰⁴ See A. Tversky and D. Kahneman "The Framing of Decisions and the Psychology of Choice". (1981) 211 *Science* 453 which describes the results of a number of experiments in this regard and posits a number of principles to explain the results.

¹⁰⁵ Research demonstrating the impact of variations in the presentation of information on the selection of alternative therapies is reported by B.J. McNeil, S.G. Pauker, H.C. Sox and A. Tversky "On the Elicitation of Preferences for Alternative Therapies". (1982) 306 *New England Journal of Medicine* 1259.

was framed in terms of the savings or loss of life.¹⁰⁶ This experiment illustrates that when making choices with respect to gains or benefits, individuals are risk averse; when making a choice involving losses, individuals are risk taking. In this experiment this characteristic of individual's preference functions were not, however, responding to any change in the consequences of the decision but only to a change in the terms in which it was expressed.

The same researchers have reported a number of other interesting and anomalous characteristics of individuals' decision making behaviour. This study found that in addition to taking on the characteristic S-shaped curve that would be predicted by economic theories of marginal utility, individuals' preference functions are skewed by a number of other identifiable concerns. These include: the failure to combine known prospects in order to effectively compare options in the course of making a decision;¹⁰⁷ discrepancies between the perceived or effective decisional probability and the actual probability on which it was based;¹⁰⁸ and the differential treatment of losses and gains depending on the frame of reference and such factors as the reference to a psychological "minimal account".¹⁰⁹ In addition to effects on the choices that are made by decision makers, the choice of a frame of reference can also affect the decision maker's subjective experience of the outcome and thereby further increases the ethical implications that follow from the choice of a decisional frame.

A study has demonstrated that the above principles can be expected to cause significant variations in choices made with respect to the selection between alternative medical treatments.¹¹⁰ This study involved populations consisting of medical patients, graduate students and doctors, each of whom were asked to choose between alternative therapies for lung cancer. The subjects were asked to choose between surgery, which offered a higher five year survival rate and radiation

¹⁰⁶ A. Tversky and D. Kahneman "The Framing of Decisions and the Psychology of Choice". (1981) 211 *Science* 453 at 453. The choice in each frame is exactly the same; the first choice providing a sure saving of 200 lives and a sure loss of 400 lives, while the second provides a one third chance of saving 600 lives and a two thirds chance of losing 600 lives.

¹⁰⁷ *Ibid* at 454.

¹⁰⁸ *Ibid* at 455-456, the certainty and pseudocertainty effects being but two explanations of such anomalies.

¹⁰⁹ *Ibid* at 546-547.

¹¹⁰ See B.J. McNeil, S.G. Pauker, H.C. Sox and A. Tversky "On the Elicitation of Preferences for Alternative Therapies". (1982) 306 *New England Journal of Medicine* 1259 which referred to the experiments and research discussed above.

treatment which provided a better short term survival rate (one year) but a lower survival rate over the longer term. The study found that all groups had large differences in the choice of therapy depending on whether the prospects were framed in terms of death or survival. Decisions based on the presentation of the alternatives in terms of the probability of survival favoured surgery to a greater extent than did those based on the probability of dying (probably due to the greater awareness of the risk of perioperative death).¹¹¹ To their surprise, the researchers found that this effect "was not generally smaller for physicians (who had considerable experience in evaluating medical data) or for graduate students (who had received statistical training) than for patients (who had neither).¹¹² This report concluded:¹¹³

One might be tempted to conclude from this study that there is no point in devising methods for the explicit elicitation of patient's preferences, since they are so susceptible to the way that the data are presented, and to implicit suggestions and other biases. However, it should be noted that the preferences expressed by the physicians, which are likely to play an important part in the advice that they give to patients, were subject to the same biases. In addition, there is little reason to believe that more informal procedures in which the treatments are described in general terms without quantitative statistical data are less susceptible to the effects of different methods of presentation.

Variations in types of data presentation can be used to assess the sensitivity of preferences with respect to the available alternatives. If a patient prefers surgery over radiation therapy, for example, whether the data are presented as cumulative probabilities or as life expectancy and whether the probabilities are presented in terms of mortality or in terms of survival, the preference may be assumed to be reasonably certain. If, on the other hand, a change of presentation leads to a reversal of preference, then additional data, discussion, or analyses are probably needed. We suggest that an awareness of the effects of presentation among physicians and patients could reduce bias and improve the quality of medical decision making.

These above concerns suggest that the requirements for a consent to be properly informed should reflect these limits on individual's rational capacities and present the question from different perspectives so as to reduce the impact that the manner of presentation could otherwise be predicted to have.¹¹⁴

¹¹¹ Ibid at 1262.

¹¹² Ibid.

¹¹³ Ibid at 1262.

¹¹⁴ Typically this would require that risk/benefit information should be presented in a manner which emphasizes both the probability and consequences of success and the probability and consequences of failure. Similarly other known tendencies, such as those associated with the certainty and pseudo-certainty effects should be identified to decision makers so as to make them aware that these are known tendencies.

This research, and the ease with which it is possible to affect the choice by the framing of the question, demonstrate that a strict test of understanding could be failed by many people insofar as it could be shown that they were making decisions in an inconsistent or incoherent manner. This work also demonstrates the close interrelationship between the decisional context and the individual's capacity in that context. Alternatively, the evidence that even persons of high intelligence tend to make irrational decisions and are affected in their choice by the manner of presentation, has been employed to support the proposition that it is desirable that patients defer to medical authorities and waive their informed consent rights. While this option may be preferred and should be available to "capable" decision makers, the ideal of patient autonomy makes it preferable that we respond to this data by developing techniques for neutralizing the impact of such considerations and for enhancing patients' abilities to meaningfully participate in decisions concerning medical services.

Interrelationships between the presentation of information and capacity have been found to produce other significant effects bearing on the successful attainment of the objectives of informed consent. Noting the practical difficulties inherent in the effective implementation of the requirements for informed consent,¹¹⁵ Taub and Baker posited that a direct testing protocol could help to ensure that the aims of informed consent were met, or in cases involving incapable individuals, that the requirements for the consent of a substitute were met. Their studies additionally found that the actual testing of individuals for memory and understanding of the consequences of a treatment decision served to improve both the understanding and the apparent decisional capacity of the individual. Different tests of comprehension were administered; the first allowed the participants to look at and review the written material as they answered the questions, the second involved this procedure with the addition of feedback, immediately correcting any incorrect answers of the test, and the third provided for up to three cycles of testing with feedback and corrected answers. All participants were tested using both the same questions and a set of additional questions. The two initial tests indicated that "relative losses associated with low vocabulary levels may actually be due to an incomplete

¹¹⁵ See H.A. Taub and M.T. Baker "A Reevaluation of Informed Consent in the Elderly: A Method of Improving Comprehension Through Direct Testing". (1963) *Clinical Psychology* 17 at 17 and H.A. Taub and M.T. Baker "The Effect of Repeated Testing Upon Comprehension of Informed Consent Materials by Elderly Volunteers". (1963) 9 *Experimental Aging Research* 135 at 135. These materials note that failures of understanding in the informed consent context are common and, that notwithstanding the reading of information sheets and compliance with written consent requirements, that "subjects taking part in research projects have been unaware that they were even in a study". It is also noted that these deficiencies have led some authors to conclude "that the goal of fully informed consent is unrealistic and unobtainable."

understanding of the information" and "that there was a significant improvement in memory at all vocabulary levels relative to the group that did not have the comprehension test".¹¹⁶ The multiple trial tests was found to be "very successful in significantly increasing comprehension scores"¹¹⁷ and the researchers concluded:¹¹⁸

... by incorporating such tests into the informed consent process we can eliminate the issues and problems raised by faulty memories of the information that is presented. Comprehension tests would provide a permanent record of what was known during the sign-up procedures. Second, the answers given on each test can provide a direct evaluation of the clarity of information presented. This can be used generally for improving the overall presentation and specifically with each volunteer for determining what points of information need to be stressed, simplified and clarified during feedback.

The third and perhaps most important advantage of using multiple comprehension trials is as a screening device to determine those elderly individuals not able to understand the information.

In a subsequent study the same authors tested the effects of multiple test trials of comprehension on four WAIS vocabulary subgroups and as well employed two forms that differed in the level of reading difficulty. In addition to supporting "previous observations of large and significant deficits in comprehension that vary inversely with vocabulary level"¹¹⁹ this study concluded that:¹²⁰

With repeated testing, at least 90% of the comprehension questions were answered correctly by each of the subgroups with vocabularies of 40 (WAIS) and above. For these elderly participants, the final performance levels were sufficiently high to suggest that the multi-trial approach represents a viable solution to the problem of insuring that materials are understood during informed consent procedures.

The advantages of using the multi-trial approach is less apparent for individuals with WAIS levels below 40. Although there was a significant improvement with repeated trial, the final mean comprehension score of 68% correct is not considered to be high enough to ensure that this material was understood ...

Even if no further significant improvements can be achieved, the multi-trial approach would still be useful as a screening device to isolate those individuals who are not capable of understanding technical information. ...

¹¹⁶ H.A. Taub and M.T. Baker "A Reevaluation of Informed Consent in the Elderly: A Method of Improving Comprehension Through Direct Testing". (1983) *Clinical Psychology* 17 at 18.

¹¹⁷ *Ibid* at 19.

¹¹⁸ *Ibid* at 20.

¹¹⁹ H.A. Taub and M.T. Baker "The Effect of Repeated Testing Upon Comprehension of Informed Consent Materials by Elderly Volunteers". (1983) 9 *Experimental Aging Research* 135 at 137 referring to the findings reported in H.A. Taub, G.E. Kline and M.T. Baker "The Elderly and Informed Consent: Effects of Vocabulary Level and Corrected Feedback". (1981) 7 *Experimental Aging Research* 137.

¹²⁰ H.A. Taub and M.T. Baker "The Effect of Repeated Testing Upon Comprehension of Informed Consent Materials by Elderly Volunteers". (1983) 9 *Experimental Aging Research* 135 at 137-138.

The inherent difficulty level of the tests used to measure comprehension and memory is a neglected area in the literature. The findings of a significant difference between Forms A and B for comprehension as well as interaction with vocabulary level for memory suggest care must be taken in construction of questions and format for tests. A post-hoc evaluation of the two test forms indicated a significant interaction with respect to the number of words in each alternative answer. ... Form B, which led to better performance, had more words in the stem ($p < .10$) and fewer words per alternative answer ($p < .05$) than Form A. ... Although further research is needed, it would appear that this recommended format may also be the one of choice for use with elderly adults in situations involving informed consent.

The generally poor levels of memory performance as well as the lack of improvement in memory following multiple comprehension trials, though unexpected, also appears to be consistent with the findings from previous studies of informed consent. Studies with long delays between the presentation of the information and the evaluation of memory have found low performance levels even when the investigators believe that all the material was presented adequately and was understood. ... This suggests that delayed memory scores are not appropriate indicators of what may have been known at the time when informed consent was obtained.

These studies emphasize the need for careful, neutral, repeated presentation of information with feedback to ensure comprehension. In order to avoid biasing the decision, the information should be presented in terms of both the probability of success and the probability of failure. The decision maker should be informed in language that he or she is capable of comprehending and assessed in terms of his or her functional rather than abstract understanding.

Review of Statutory and Case Law Developments

Unfortunately, there has been very little case law development to assist one in the interpretation of the relevant statutory provisions on concerning capacity to make treatment decisions.¹²¹ As will be noted below, the decisions that do exist have been made by lower courts and have not provided rules of general application, nor have there been enough decisions for any trends to have become clearly evident.

In *Clarke v. Clarke*¹²² County Court Judge Matheson rejected the application that was brought to have Justin Clarke declared mentally incompetent. Justin suffered from cerebral palsy and had been diagnosed as being mentally retarded. Although he could not speak, he could communicate through a Bliss symbols board. The judge, not being satisfied beyond a reasonable doubt that the affidavit evidence proved that the respondent was a mentally incompetent person, directed a trial of

¹²¹ Please see the relevant provisions of the Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended) that are reproduced in the Appendices.

¹²² (1982), 40 O.R. 383. For further discussion of this case, see Appendix II and Appendix III.

the issue.¹²³ After noting that the civil balance of probabilities standard of proof applied to a trial of the issue of incompetency, the judge stated that physical limitations should not be considered in an assessment of mental competency. After receiving extensive testimony on the subject of Justin's abilities and limitations, the judge decided that he was mentally competent. The evidence that Justin could communicate effectively, was fully aware of his surroundings and knew what he wanted, appeared to be the determinative factors in this case although the judge did not specify the criteria upon which he based his decision.

Consent to Treatment

The *Mental Health Act*¹²⁴ defines mentally competent to make a treatment decision as meaning "having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed and being able to appreciate the consequences of giving or withholding consent".

In *Re Howlett and Karunaratne*¹²⁵ the Court found that the patient was suffering from "delusions" and that although this factor was not determinative of the issue of mental competency, the delusions in this case related to her "ability to understand the nature of her illness and her ability to appreciate the consequences of giving or withholding consent". The judge decided that even though the patient may "have an appreciation of manic depression" he found that because of the nature of her delusions she lacked "an understanding of the nature of her illness and was therefore not mentally competent". He also concluded that because of the nature of her delusions "she did not understand the consequences of giving or withholding consent".

In *McKay v. O'Doherty*¹²⁶ the Ontario District Court dealt with an appeal from a Review Board decision in which the Appellant had been found committable and incompetent to consent to treatment. The Court found that s.1(g) and s.35(1)(b) required consideration of three parameters, these being:

¹²³ The proceeding was brought under the *Mental Incompetency Act*, sections 7 and 8.

¹²⁴ See s.1(g) and s.35(1)(b) reproduced above.

¹²⁵ (1988), 64 O.R. (2d) 418.

¹²⁶ (1989), [1989] O.J. No. 965.

- (1) That the patient have the ability to understand the nature of the illness for which treatment is proposed;
- (2) That the patient have the ability to understand the treatment proposed; and
- (3) That the patient be able to appreciate the consequences of giving or withholding consent.

With respect to the onus and burden District Court Justice Kozak noted:

A person is not mentally competent unless all three elements are present. The onus is upon the respondent to establish on a balance of probabilities that the appellant lacked at least one of the three elements in order to establish mental incompetency.

In this case it was found that despite "there being no doubt that the Appellant suffers from overwhelming delusions as part of her paranoid schizophrenia ... "she remains a very intelligent person who was able to function at a high level as a student". It was then concluded that as a result of her intelligence and experience, she had "an understanding of the nature of the illness for which treatment is proposed, as well as understanding the treatment proposed". The patient denied that she suffered from any psychiatric illness and in particular denied that she was suffering from paranoid schizophrenia and accordingly saw no need to accept the proposed medication. This case turned on the requirements for appreciation under the Ontario *Mental Health Act*. In this regard the judge noted that the counsel for the appellant took the position that this element required only an intellectual outward understanding and not a personal insight into one's own situation, whereas counsel for the respondent argued "that unless a person has an insight or personal awareness of the existence of the mental disorder that it is not possible to appreciate the consequences of giving or withholding consent". In this regard the judge decided that:

The giving or withholding of consent is not something that should arise in the abstract but should relate to the awareness of an existing condition. An ability to appreciate the consequences of giving or withholding consent could hardly be considered an informed consent or withholding, if the person denies an existing condition. Denial of the illness places the appellant in the position where she cannot appreciate the consequences of the medications as related to her personal needs.

Accordingly, I find that the appellant did not understand the consequences of giving or withholding consent, and the appeal of the Board's decision under Section 35(1)(b) is hereby dismissed.

The above decisions are not very helpful as they seem to be more conclusory than analytical in nature.

2. Capacity to Make Financial Decisions

There are a variety of kinds of financial decisions. Among the most important are contracts, gifts, testamentary dispositions, and marriage. In each of these transactions, slightly different considerations must be demonstrated in order to prove that the decision represents an informed, voluntary and intentional choice of the decision maker.

In each context an individual's capacity may be questioned either prospectively or retrospectively. We are concerned that the introduction of general tests that an individual would have to pass before entering into a transaction could serve to infringe an individual's liberties and lead to a weakening of the presumption of capacity in addition to the cost that would be imposed on all those entering into transactions. Furthermore, the retrospective assessment of capacity is, as will be seen in the review of the case law on these subjects, often inextricably connected to related concerns about duress, undue influence and other factors beyond the scope of this report. The practical difficulties that flow from the wide range of circumstances in which an individual's reduced capacity may give rise to their being abused by the unscrupulous, make it virtually impossible and probably undesirable for the Enquiry to attempt to develop guidelines of universal application that could be employed by the courts when hearing cases brought on these grounds. For this reason we suggest that the rules that should apply to the retrospective determination of capacity in such cases are probably best left to be developed in equity by the common law or alternatively through amendments to consumer protection, sale of goods or similar legislation.

The assessment of capacity may be triggered in three different ways. Firstly, by the individual, a relative or friend taking action to protect the individual or their estate, usually in the form of guardianship proceedings. Secondly, at the instigation of a professional or some other person in a fiduciary relationship with the decision maker. Thirdly, as a result of admission to a psychiatric facility or other chronic care institution. The Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (the Fram Report), which is presently being reviewed by Mr. Bernard Starkman, provides an extensive analysis of the issues surrounding the appointment of substitute decision makers and should be reviewed by anyone wishing further information on this subject. Fram notes the incoherence in the present legislation dealing with mental incapacity and suggests its replacement with the proposed legislation that had been drafted by the Advisory Committee.

At present, the *Mental Incompetency Act*¹²⁷ provides the primary mechanism by which the court may declare an individual to be mentally incompetent. This statute defines mental incompetency in the following terms:

a.1 In this *Act*,

- (e) "mentally incompetent person" means a person,
 - (i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or
 - (ii) who is suffering from such a disorder of the mind, that he requires care, supervision and control for his protection and the protection of his property;
- (f) "mental incompetency" means the condition of mind of a mentally incompetent person;

Applications under this statute give rise to one of two results. Either the individual is found competent or alternatively he or she is determined to be globally incompetent. This *Act* is generally recognized as outdated and fails to reflect current thought which sees competency as being a marginal construct. These concerns were among those addressed by the Fram Committee which defined capacity in the following terms:¹²⁸

The ability to make an informed choice is the essence of mental capacity. Mental incapacity means the incapacity to understand information relevant to making a decision or the inability to appreciate the consequences of a decision or lack of a decision.

Mental incapacity must be defined so that persons who are capable of making a choice or decision will not have these choices or decisions interfered with, even if most members of the community consider them eccentric or even bizarre. "Capable" would include the ability to make choices or appreciate consequences with the assistance of others. We receive information from explanation and thus we rely on explanation for understanding. Therefore, when a person accepts the assistance of another and is able to understand a concept that would not otherwise be understood, the person is capable. ...

The Committee recommends:

Mental incapacity should be defined so that legislation to provide substitute decision making for persons who are incapable cannot be used to interfere with the freedom of action of persons who know what they are doing and appreciate the consequences of their acts, or can do so with assistance.

While we fully agree with the sentiments contained in the above definition, we are concerned that the word "assistance" could be misconstrued and read too broadly if taken out of context and would therefore qualify it with the word

¹²⁷ R.S.O. 1980, c.264.

¹²⁸ Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons, 1987 at 91-92.

"informational". Having noted the importance of the provision of clear, impartial and thorough information in the previous section, we note only that this requirement is consistent with principles advocated by both Fram and this report.

The effective implementation of the principle of marginal capacity requires that financial decisions be ranked in terms of the number and complexity of factors that need to be taken into account and also in terms of the impact that such a decision can be expected to have on the decision maker. While it would be preferable that a system be developed to allow such determinations to be made apart from the decision maker, we do not believe this to be practical at the present time and therefore recommend that capacity determinations be made in accordance with the protocol set out in this report. More specifically, with the exceptions of insignificant decisions¹²⁹ and individuals who are clearly globally incapable, we recommend that the individuals' capacity should be assessed in terms of the specific decision that they are required to make.

Review of Statutory and Case Law Developments

Please see the relevant statutory provisions that are reproduced in the Appendices.

a. Contract

The essence of a contract is an agreement between the parties to be bound by a set of conditions that the parties have acknowledged as defining the law governing relations between them with respect to the subject matter of the contract. While the legal requirements for offer, acceptance, consideration, and agreement, etc. fall outside the purview of this report, these elements impinge on the determination of capacity insofar as these factors must be dealt with by a decision maker in order to form a valid contract.

Contract - Case Law

In contract law the defence of mental incapacity has been heavily influenced by the nature of contract law and qualified by the development of other remedial and restitutionary doctrines. As a result, mental incapacity in this area has often been conflated with other issues that lead the courts of equity to provide relief for unconscionability. Undue influence, duress and lack of mental capacity have thus

¹²⁹ For which the decision makers preferences will prevail.

been associated.¹³⁰ Mental incapacity has been considered significant only where it impedes the "business sense" of the individual in question. This requirement has served to make such a determination reliant on a combination of the individual's business experience and his or her mental capacities.¹³¹ Noting the difficulties inherent in any attempt to distil a "pure" definition of capacity in light of these concerns, the following are some relevant decisions on this subject:

The English Court of Appeal in *The Imperial Loan Co. Ltd. v. Stone*¹³² decided that before a contract could be invalidated by reason of incapacity, it must be proven that one party to the contract **knew** that the other party was "so insane as not to be capable of understanding what he was about". In *Fyckes v. Chisholm*¹³³ the High Court of Justice removed the requirement that the stronger party be aware of the incapacity, and mentioned appreciation of the transaction, memory of the negotiations, and understanding that he was entering into the contract in question, as being elements that led the court to find that the individual in question was capable of entering into the disputed contract.

In *McNab v. Imperial Trust Co.*¹³⁴ the Supreme Court of Canada affirmed the Ontario Court of Appeal determination of incapacity with respect to promissory notes based on the following test:

But the question is not whether he could be brought to understand that he was signing a note; it is whether he would understand that he was signing a series of notes, whether he remembered from time to time what notes he had already signed, whether he had capacity to understand the whole body of transactions.

¹³⁰ See *Trusts & Guarantee Co. v. Fryfogel* (1914), 6 O.W.N. 308 (K.B.).

¹³¹ In this regard S.M. Waddams *The Law of Contracts*, (2nd ed.), (Toronto: Canada Law Book, 1984) at 501 noted:

Mental incompetence is a comparative concept and can vary from certifiable insanity to something not much worse than commercial naivete. ... the Courts of Equity would set aside contracts on the grounds of weakness of intellect far short of what would justify an order of incompetency. Similar relief is given in cases of senility and simple ignorance of business matters. Thus relief is available on the grounds of unconscionability where undue advantage is taken of weakness of intellect and, *a fortiori*, in cases of more serious incompetence. (footnotes deleted).

¹³² (1892), [1892] 1 Q.B. 599. For further discussion of this case, see Appendix IV.

¹³³ (1911), 3 O.W.N. 21.

¹³⁴ (1935), [1935] 4 D.L.R. 570.

In *Bank of Nova Scotia v. Kelly*¹³⁵ the Court stated that in order to determine the validity of the contract, it was necessary to determine whether or not the contracting party was incapable of understanding the terms of the notes and of forming a rational judgment of their effect upon his interests by reason of his incapacity.

The common law provided strict protection for individuals that were under the age of majority at the time of the contract. With the exception of contracts for "necessaries" (for which a reasonable price must be paid) minors were considered to be incapable of entering into contracts and could not be bound by such a contract unless they chose to ratify it upon reaching the age of majority.

For a variety of reasons, many of which are unrelated to the issue of the actual mental capacity of the party in question, the common law has failed to develop a test for capacity to contract which is both sufficiently clear and universal so as to be helpful to the Enquiry in this regard.

b. Gifts

A gift is a transaction involving the transfer of property from the donor to the donee and is generally not the result of a bilateral contract between the parties. A valid gift requires that the transfer be the voluntary, deliberate and well understood act of the donor.

Gifts - Case Law

As with capacity to contract, the question of an individual's capacity to make a valid gift is often associated with concerns about undue influence, confidential relationships and the requirement for independent advice. Courts appear to start from a position of scepticism whenever dealing with a situation in which anyone has given anything to persons other than immediate family without receiving adequate consideration in return, and the assessment of capacity is often coloured by a parallel inquiry into the existence of some measure of *quid pro quo* or the receipt of a perceived benefit by the donor whether tangible or otherwise. Recognizing that the determinations in such cases are often made on the basis of these concerns as much as they are on evidence of capacity, Canadian cases on this subject have prescribed the following tests.

¹³⁵ (1973), 41 D.L.R. (3d) 273 (P.E.I.S.C.).

In the recent case, *Salvation Army Canada West v. Allen Estate*,¹³⁶ the court dealt with allegations of undue influence and lack of capacity which were made with respect to the validity of a number of *inter vivos* gifts and changes to the testator's will. After an extensive review of the law on the subject of undue influence, the court turned to the capacity of the donor to make the challenged gifts and stated:

There is no doubt that the defendants were attempting to exercise control over Mrs. Allen and her financial affairs. ... While there is no doubt that Mrs. Allen was weak and vulnerable throughout the evidence she was portrayed as independent and at times stubborn. Dr. Welton had found her to be of sound mind and capable of managing her finances. Dr. Radford's assessment was similar. ... Thus the evidence falls short of concluding the influence of the defendants had any material effect upon Mrs. Allen when she conveyed the first \$10,000.00.

I have no such difficulty with respect to the gift of January 26, 1981. Mrs. Allen's health had clearly deteriorated. She was clearly more vulnerable. Her mental condition was such that she was easy prey to the persistent actions of both Mrs. McCallum and Mrs. Corney. ... At that stage in light of Mrs. Allen's mental condition whatever explanation was offered to her as to the nature of the gift could not have been effective. The gift of January 26, 1981, will therefore be set aside.

In *Gammon v. Steeves*¹³⁷ the Court of Appeal split on issues pertaining to undue influence but agreed with respect to the incapacity of one of the plaintiffs in the following passages:

Angers J.A. (Dissenting): ... Initially, I should say that the deed for the property at 16 Gordon Street should be set aside but not because of undue influence. In the case of Mrs. Gammon, because she was mentally incompetent and thus did not have legal capacity to make the transaction. In the case of Mr. Gammon, because the deed was a mistake. Mr. Gammon testified and made his position very clear that he never intended to divest himself of that property during his lifetime. ...

Hoyt J.A.: ... The evidence is clear that at that time Mrs. Gammon would have been unable to understand the nature of the transaction. Warren Davidson, a Moncton geriatrician was satisfied, after reading the various hospital records and medical reports tendered in evidence, although he did not see Mrs. Gammon, that she was mentally incompetent on August 1, 1984. Richard Morton, the Medical Director at the nursing home, who saw Mrs. Gammon regularly, was positive that Mrs. Gammon was not mentally competent on August 1, 1984 and that she would not understand the impugned transaction. Thus the deed, insofar as it pertains to Mrs. Gammon, must be set aside because of her lack of capacity.

Insofar as Mr. Gammon is concerned, although Dr. Davidson was of the opinion that he may have been suffering from a pseudo-dementia caused by his depression, the evidence establishes his mental competency on August 1, 1984. That, however, does not in itself rebut the presumption of undue influence.

¹³⁶ (1988), [1988] B.C.J. No. 802 (S.C.).

¹³⁷ (1987), [1987] N.B.J. No. 1046. For further discussion of this case, see Appendix V.

In *Alberta (Public Trustee) v. Ostapowich*¹³⁸ Miller A.C.J. dealt with a challenge to validity of an inter vivos gift. In the passages dealing with mental capacity he noted:

... Dr. Huston offered the opinion that from ... 1976 up to the present time, Tulick would not have had the mental capacity to understand the nature and significance of making a substantial gift of property or of appointing an agent to look after his financial affairs. ... he felt that Tulick was suffering from advancing senility aggravated by other physical problems and the medication he was taking for those problems.

Under cross-examination, Dr. Huston ... agreed that, at times, Tulick might understand what a legal document was but felt he would not recall the implications on a long term basis. ...

... I am completely satisfied that Dr. Huston was being objective and entirely sincere in giving his opinion as to Tulick's general mental capacity. However, he did concede that Tulick had periods of lucidity between times of confusion. ... if the court can be satisfied that on the crucial days when decisions were made by Tulick or actions taken by him, he had the mental capacity and lucidity to understand the nature and consequences of his acts, the Court must give effect to what took place.

In *Gillis v. Hulton*¹³⁹ an inter vivos transfer of land from a geriatric man to a younger man who had helped care for them for a number of years was challenged by the son of the donor in his capacity as committee of the estate of the donor. The defendant, in addition to justifying the value of the estate in terms of assistance rendered to the geriatric couple, adduced evidence of the capacity of the donor at the time of the gift. Mr. Cameron, the witness to the transfer, gave testimony to that effect:

Mr. Cameron said he felt that he had an obligation to determine whether or not the person who was asked to sign the document was lucid at the time and he said he felt that he was. He was asked whether or not, if he had known some of the evidence that was given by medical people in these proceedings that would change his thinking about the ability or competence of Duncan Gillis and he said no, that that would not have any effect, that he was satisfied in his mind that the man knew what he was doing on that occasion.

The plaintiff introduced medical evidence to counter this assertion:

Dr. Smillie in his report reviewed the numerous occasions when it was necessary to hospitalize Duncan Gillis and he referred in the course of his report to the diagnosis on those various occasions such as, significantly confused state and being quite confused, confusion, disorientation, and agitation with paranoid delusions. ... He summarized it by saying that, "It is my professional opinion that Mr. Duncan Gillis suffered from a significant degree of cognitive impairment due to Alzheimer's disease. It is also my opinion that he would be incapable of comprehending a legal document during the course of time that I had been his primary care physician".

¹³⁸ (1988), [1988] A.J. No. 938 (Q.B.).

¹³⁹ (1988), [1988] B.C.J. No. 846 (S.C.). For further discussion of this case, see Appendix V.

Dr. Olthuis ... said that during the summer of 1984 Mr. Gillis showed signs of disorientation, that although he was oriented to person he was not "orientated" if that is a good word, to time or to place; he also had severe impairment of memory and impairment of intellectual functions such as comprehension and judgment; he appeared unable to understand questions and his response to questions was inappropriate. In summary, Mr. Gillis showed features of an organic mental disorder consistent with progressive senile dementia (Alzheimer's disease or primary degenerative dementia, senile onset) and this interfered with his intellectual functions such as his ability to comprehend a legal document during the time that he had contact with him.

Dr. Anders filed a report. ... His diagnosis was the same, that he suffered from Alzheimer's type senility. ...

I should mention the evidence of Dr. Milobar who examined Mr. Gillis in February, 1984. He is an Internist and he was asked to see Duncan Gillis in connection with a possible operation, surgical intervention and to determine whether or not it would be appropriate to conduct such a surgical operation. As an Internist Dr. Milobar gave his opinion that that would be all right. He was asked if he had formed an opinion of the mental competency and he said, "I took a history and the only infirmity I found was that he was hard of hearing". He went on to say that I did not find any evidence of senile dementia".

Trainor J. then considered the *Patient's Property Act* and decided:

In the circumstances here I think that there is an onus on the defendant to establish that Duncan Gillis was mentally competent at the time that the transfer was signed on the 3rd of June, 1984. The evidence to which I have referred satisfies me that he was not competent. I am not satisfied that the defendant has discharged the onus which is on him and I find that when that document was signed on the 3rd of June, 1984 Duncan Gillis was not mentally competent ...

In *Fairchild v. Mitchell and Mattatall*,¹⁴⁰ while the majority of the Court of Appeal affirmed the trial judge's finding that there was no basis for questioning the donor's mental capacity, Justice Currie, in dissent came to the opposite conclusion. He found that the donor lacked mental capacity in that she was "incapable of understanding substantially the nature and effect of the impugned transactions" although she "was capable of understanding that she was making them". In this case, as in many others of this type, the issue of undue influence was associated with the claims of incapacity.

In *Nova Scotia Trust v. Corkum*¹⁴¹ the Court of Appeal upheld the trial judge's finding of "mental incapacity", stating that:

... the degree of mental incapacity that is relevant and material was such a degree of mental incapacity on the part of the respondent as would prevent her from substantially understanding the nature and effect of the transaction into which she was entering.

¹⁴⁰ (1959), 19 D.L.R. (2d) 521 (N.S. C.A.).

¹⁴¹ (1961), 31 D.L.R. (2d) 27 (Ont. C.A.).

In this case the complexity of the impugned transaction, which included irrevocable trust provisions and the conveyance of all or part of the donor's property, established the level of ability that was required before the donor be considered capable.

In *Royal Trust v. Diamant*¹⁴² the judge specified the degree of incapacity which must be demonstrated in order to invalidate an *inter vivos* gift as being:

... such a degree of incapacity as would interfere with the capacity to understand substantially the nature and effect of the transaction. The Plaintiff here need not prove that the donor failed to understand the nature and effect of the transaction. The question is whether she was capable of understanding it
...

c. Testamentary Disposition

Testamentary disposition requires that the testator understand the nature of the act and its impact, the extent of the property involved and the identification of those who should be considered as potential beneficiaries.

Testamentary Disposition - Case Law

The determination of capacity to make a will tends to reflect social concerns that are similar in nature to those which underlie the determination of capacity to make an *inter vivos* transfer. However, to concerns about undue influence, and the other factors mentioned above, are typically added the requirement that the testator consider the claims of all to whom they are related. The assessment of testamentary capacity may be distinguished from other forms of capacity determination in that the proponent of a will is required to satisfy the onus by proving capacity. However, although the burden is reversed, most decisions agree that the standard of proof remains a civil one.¹⁴³

In *Skinner v. Farquharson*¹⁴⁴ the Supreme Court noted the requirement that a testator "be able to rationally consider the claims of all those who are related to him and who according to the ordinary feelings of mankind are supposed to have

¹⁴² (1953), [1953] 3 D.L.R. 102 (B.C.S.C.).

¹⁴³ For a review of contrary authorities and discussion of the burden that must be born by the party propounding the will see *Sherman Estate v. Sherman* (1989), [1989] S.J. No. 59 (Q.B.).

¹⁴⁴ (1902), 32 S.C.R. 58. For further discussion of this case, see Appendix V.

some claim to his consideration when dealing with his property as it is to be disposed of after his death." The Supreme Court also referred to the case of *Banks v. Goodfellow*¹⁴⁵ for a test of capacity which has often been cited in Canadian cases on this subject (quoted below).

In *Re Davis*¹⁴⁶ the Ontario Court of Appeal referred extensively to evidence of a change in behaviour, which was attributed to a chronic medical condition, as a significant element in the assessment of capacity. In particular in this case the Court noted that:

... the eccentric behaviour of the testatrix for more than a year before the execution of the disputed will and attributed to a chronic condition of arteriosclerosis which had made serious inroads upon her cerebral arteries, affords highly relevant evidence of unquestioned weight. The malady had progressed to a point where, quite apart from its degenerating effect upon her memory and other mental faculties, it had produced in her a complete personality change ...

The 1843 decision of *Mudway v. Croft*¹⁴⁷ was quoted for the proposition that such evidence was an essential indicia of capacity and the following quote, which Sir Herbert Jenner Fust had reproduced from a Treatise on Medical Jurisprudence, was repeated in the Court of Appeal decision:

Madness is not indicated so much by any particular extravagance of thought or feeling, as by a well marked change of character, or departure from the ordinary habits of thinking, feeling, and acting, without any adequate external cause.

The dramatic changes that the testator had made with respect to the beneficiaries of the will were assigned considerable importance by the Court which remarked that this was a salient fact that should have been considered by the witnesses who had determined the testator to be capable at the time the disputed will was prepared. Later in the judgment, the Court discussed the difficult subject of the relationship between the capacity of the testator and the apparent "reasonableness" of the disposition that she had specified. In this regard the Court stated:

In the present case the will of May 26, 1959 ... presents a marked departure from the scheme of her previous testamentary dispositions, and more particularly it stands out as an entire subversion of the

¹⁴⁵ (1870), L.R. 5 Q.B. 549. For further discussion of this case, see Appendix III.

¹⁴⁶ [1963] 2 O.R. 666 (C.A.). For further discussion of this case, see Appendix III and Appendix V.

¹⁴⁷ (1843), 3 Curt. 671, 163 E.R. 863.

dispositions made in the testamentary instruments of May 4th and May 6th, 1959. This is a circumstance of vital significance which raises in limine the question as to whether the deceased woman's capacity was adequate to the making of the subsequent and entirely varied disposition of her estate.

In *Harwood v. Baker* (1840), 3 Moo. P.C. 282, 13 E.R. 117, Erskine, J., stated at p. 291: if he (the testator) had not the capacity required, the propriety of the disposition made by the Will is a matter of no importance. If he had it, the injustice of the exclusion would not affect the validity of the disposition, though the justice or injustice might cast some light upon the question as to his capacity.

After reviewing the changes that Mrs. Davis had made to her wills the Court observed that it was difficult to apprehend why the testator suddenly wholly ignored, in her will, "the nature of the claims of those who were the natural objects of her bounty" and then quoted the following "authoritative statement of the law on the subject of testamentary capacity" from "the classic judgment of Cockburn, C.J.", in *Banks v. Goodfellow*:¹⁴⁸

It is obvious, in either case, that to the due exercise of a power thus involving moral responsibility, the possession of the intellectual and moral faculties common to our nature should be insisted on as an indispensable condition. It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties — that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.

The Court then referred to the decision of Boyd C. in *Murphy v. Lamphier*¹⁴⁹ in which the following quote from *Simpson v. Gardner's Trustees*¹⁵⁰ was adopted:

The grand criterion by which to judge whether the mind is injured or destroyed, is to ascertain the state of the memory. It is memory that affords us all the materials on which to exercise judgment, and to arrive at a conclusion or resolution. Without memory the mind cannot act, and it is the first of the intellectual faculties which fail, where the mind is in a state of decay.

With respect to the process of the assessment of capacity the Court noted that:¹⁵¹

¹⁴⁸ (1870), L.R. 5 Q.B. 549. For further discussion of this case, see Appendix III.

¹⁴⁹ 31 O.L.R. 287. For further discussion of this case, see Appendix V.

¹⁵⁰ (1833), 11 Ct. of Sess. 1049 at pp. 1051-2. For further discussion of this case, see Appendix V.

¹⁵¹ In support of this contention the Court of Appeal cited *Re Price, Spence v. Price* (1946), [1946] 2 D.L.R. 592 at p. 601, [1946] O.W.N. 80 at p. 84 in which Roach, J.A., quoted a passage from a judgment of Sir J. Hannen, where that learned jurist was discussing the question of a sound mind as meaning a disposing mind in *Boughton and Marston v. Knight* (1873), L.R. 3 P. & D. 64. For further discussion of the *Boughton and Marston v. Knight* case, see Appendix III.

Whether a person has testamentary capacity, i.e., whether he has a sound and disposing mind, raises a practical question which, so far at least as evidence based on observation and experience is concerned, as contrasted with evidence based on pathological findings, may be answered by laymen of good sense as by doctors.

The Court concluded that:

Having regard to the history of this unfortunate woman, her great physical and mental deterioration, her memory lapses, her morbid resignation and surrender to obsessions which overpowered her weakened intellect, the compelling and overmastering conception that she had to do her part to rid the world of cancer may well have exercised dominion over her mind to such a degree as to operate on it in the same way as if she were haunted or obsessed by some fixed delusion. It is highly probable that it was an obsessive compulsion, so overpowering and importunate, that it ejected all other relevant considerations from her mind and that she was irresistibly impelled to yield to it.

... She was therefore unable at the time of making the impugned will to dispose of her property with understanding and reason, or with judgment and discernment, hence it was not the will of a person of sound and disposing mind and memory.

The onus of proving testamentary capacity where any dispute or doubt exists upon the matter is cast upon the proponents of the will. Where, as here, the will is an inofficious one and constitutes a marked departure from all prior dispositions and there is a history of progressive impairment of the mental faculties resulting from arteriosclerosis of the cerebral artery producing loss of memory and character changes, with other evidence suggestive of mental deficiency, that burden of proof is considerably increased. In my opinion the evidence falls far short of satisfying the heavy burden resting upon the appellants ...

In *Re Schwartz*¹⁵² the Ontario Court of Appeal dealt with a challenge to the capacity of the testator which arose because the testator had changed his will so as to disinherit his son Jack and his children. The testator's physician testified that the testator's mental ability was not impaired, but a psychiatrist, who relied solely on hospital records, indicated that some impairment of capacity would probably have existed. A neurologist who had briefly visited the testator indicated that the testator had some mental impairment.

In this case the trial judge admitted the will to probate and on appeal the majority, Laskin J.A. dissenting, held the appeal must be dismissed. The majority based their decision on the inherent limitations on the validity of the testimony of the psychiatrist and neurologist, and the contrary testimony from the testator's doctor, his practical nurses and a business associate. The majority also relied on the fact that the disputed will varied from previous wills only insofar as it disinherited his son Jack, a change that was explained by the testator's displeasure

¹⁵² (1970), [1970] 2 O.R. 61. For further discussion of this case, see Appendix III.

at Jack's engaging in a business dispute with his brothers. With respect to the evidence and the test of capacity to be employed in such cases Evans J.A. stated:

In my opinion the evidence in favour of testamentary capacity is substantial and supports the finding of the trial Judge in that regard. The opinions of Dr. Gray and Dr. Humphrey suffer in one case from a total lack of observation of the testator and in the other from a very limited period during a time when the testator was seriously ill. I adopt the statements of Laidlaw, J.A., in *Re Price; Spence v. Price* (1946), [1946] O.W.N. 80 at pp. 81-2, [1946] 2 D.L.R. 592 at p. 595:

The quality of a person's mind manifests itself by conduct and expressions of thought. The conclusions to be reached from such evidence do not depend for their correctness upon the possession or exercise of special skill or knowledge. A judgment may be formed by a person of sound mind and reason, exercising powers of observation and deduction, without the use of any scientific learning whatever. It is a practical question which may be answered by a lay-man of good sense with as much authority as by a doctor. The weight to be properly given to the evidence touching the question depends in part upon the extent of the observations made by a witness. Whenever there is a marked departure from a previously existing pattern in the disposition by a testator of his estate, one seeks to ascertain from the circumstances the reason for such change. If the circumstances are suspicious then there is an onus on the party propounding the will to satisfy the conscience of the Court that the document is the last will of the testator made at a time when he was free of undue influence and in possession of a "disposing mind and memory".

The judge then quoted the following definition from the decision of Rand, J., in *Leger v. Poirier*:¹⁵³

A 'disposing mind and memory' is one able to comprehend, of its own initiative and volition, the essential elements of will-making, property, objects, just claims to consideration, revocation of existing dispositions, and the like ...

Laskin J.A., dissenting, found the evidence of the neurologist and psychiatrist of the progressively debilitating nature of the testator's illness and evidence of erroneous beliefs with respect to the relationships of his sons indicated a want of the comprehension essential to testamentary capacity. Therefore, the executors had not discharged the onus of proving testamentary capacity. Notwithstanding his decision as to disposition, Justice Laskin made a number of comments about the concept of mental incapacity which were not contradicted by the majority.

I lead into the applicable law by stating two propositions which are merely starting points; first, the proponents of the will must establish testamentary capacity; and, second, proof that goes only to show that the testator knew and approved of the contents of the will is not enough to show testamentary capacity. This second proposition must be qualified in the light of the judgment of Ritchie, J., speaking for the Supreme Court (Judson, J., dissenting) in *McGregor v. Ryan*¹⁵⁴ said: "If a will has been shown to have been duly executed after having been read over to or by a testator who appears to understand it, then it will generally be presumed that he had testamentary capacity at the time of its execution but

¹⁵³ (1944), [1944] S.C.R. 152, [1944] 3 D.L.R. 1 at 11. For further discussion of this case, see Appendix V.

¹⁵⁴ (1965), [1965] S.C.R. 757 at 760, 53 D.L.R. (2d) 126 at 133-134.

if, in the course of proving the will, it becomes apparent that there are circumstances raising a well-grounded suspicion as to whether the document indeed expresses the true will of the deceased, then a heavy burden lies on the Court to look beyond the presumption created by compliance with these formalities and be satisfied that the will was the free act of a testator who at the time had a "disposing mind and memory" in the sense defined by Rand J. in *Leger, et al v. Poirier* ..."

Justice Laskin quoted extensively from the section of the decision in *Leger, et al v. Poirier*¹⁵⁵ that had been cited by the majority, (quoted above):

But there is no doubt whatever that we may have testamentary incapacity accompanied by a deceptive ability to answer questions of ordinary and usual matters: that is, the mind may be incapable of carrying apprehension beyond a limited range of familiar and suggested topics. A "disposing mind and memory" is one able to comprehend, of its own initiative and volition, the essential elements of will-making, property, objects, just claims to consideration, revocation of existing dispositions, and the like; this has been recognized in many cases.

...

Merely to be able to make rational responses is not enough, nor to repeat a tutored formula of simple terms. There must be a power to hold the essential field of the mind in some degree of appreciation as a whole, and this I am satisfied was not present here.

He reviewed the decision of Cockburn, C.J., in *Banks v. Goodfellow*¹⁵⁶ for an elaboration on the elements to be considered when assessing whether the testator had a "sound and disposing mind and memory" and then gave his own interpretation of these parameters:

It is essential to the exercise of [testamentary] power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties ...

In more contemporary terms, they have been stated as follows: The testator must be sufficiently clear in his understanding and memory to know, on his own, and in a general way (1) the nature and extent of his property, (2) the persons who are the natural objects of his bounty and (3) the testamentary provisions he is making; and he must, moreover, be capable of (4) appreciating these factors in relation to each other, and (5) forming an orderly desire as to the disposition of his property: see *Atkinson on Wills* (1953), 2nd ed., p.232; 39 Hals., 3rd ed., pp. 855-6.

In the present case, the issue of capacity touches items (4) and (5) of this last enumeration. There can be no question of want of capacity if there is merely forgetfulness or mistake or prejudice, or even eccentricity; and, of course, age alone is not a disqualifying consideration. The critical inquiry is whether mental deficiency or disease of the mind supported the mistake or prejudice upon which the testator acted in making the challenged disposition. Evidence bearing on these elements have been,

¹⁵⁵ (1944), [1944] S.C.R. 152 at 161-2, [1944] 3 D.L.R. 1 at 11-12. For further discussion of this case, see Appendix V.

¹⁵⁶ (1870), L.R. 5 Q.B. 549 at 565. For further discussion of this case, see Appendix III.

generally, of three types: first, observable matters respecting the conduct and condition of the testator; secondly, expert opinion evidence as to the testator's competency; and, thirdly, the nature of the dispositions made by the testator. Since a testator with testamentary capacity may be as capricious as he wishes, it may be incongruous or question-begging to consider the terms of the will on the question of capacity. They may have marginal value but ought none-the-less to be taken into account, especially where the other evidence on the issue suggests a relationship with the dispositions made by the testator.

On the limitations of lay witness testimony on the subject of mental capacity, he said:

Evidence as to the conduct and condition of the testator in this case was given on behalf of the proponents of the will mainly through lay witnesses; the chief reliance of the contesting son Jack was on the expert evidence of a neurologist and of a psychiatrist. In considering the weight of the evidence, it is important to remember that it must be judged for its bearing on capacity; and although lay witnesses who knew the testator may give admissible evidence on that issue, the fact that the testator in this case was old and was suffering from an organic disease of the brain and had other debilities at the material time, would indicate the need of a cautious view of the lay evidence, over and above the caution to be exercised with respect to the evidence of beneficiaries who were associated with the making of the will. In the circumstances present here, psychiatric evidence would seem to be particularly appropriate on the important question of the testator's capability of knowing the relevant facts.

Recent cases have done little to clarify the residual areas of uncertainty and have tended to refer to the earlier cases for the law.¹⁵⁷ In *Alberta v. Cushman*¹⁵⁸ the Court of Appeal endorsed the trial judge's reference to *Banks v. Goodfellow*, supra, for the test for testamentary capacity but was not satisfied that it was properly applied in that case and ordered a new trial. In *Salvation Army Canada West v. Allen Estate*,¹⁵⁹ the Court considered the validity of a will that had been propounded by an incompetent testator and stated that while a "declaration of incompetency is not *per se* synonymous with a lack of testamentary capacity",¹⁶⁰ if "the declaration is a consequence of a mental disorder that impairs the testatrix's judgment in testamentary disposition matters, then the declaration will warrant a finding of testamentary incapacity."

¹⁵⁷ For example, see *Konec v. Gyalay* (1988), [1988] A.J. No. 335 (Surr. Ct.), *Koster v. Falinski* (1988), [1988] M.J. No. 628 (Q.B.) (which referred to *Banks v. Goodfellow*, *Re Schwartz*, *Leger v. Poirier*, all supra), *Re Lagasse Estate* (1988), [1988] S.J. No. 757 (Surr. Ct.), *Re McPhee Estate* (1965), 52 D.L.R. (2d) 520 (B.C. Surr. Ct.).

¹⁵⁸ (1988), [1988] A.J. No. 1041 (C.A.) reversing (1987), [1987] A.J. No. 1120 (Q.B.), see also *Alberta v. Dickson* (1986), [1986] A.J. No. 551 (Q.B.) which referred to the cases discussed above as the sources of the test for testamentary capacity.

¹⁵⁹ (1988), [1988] B.C.J. No. 802 (S.C.).

¹⁶⁰ The decision in *Re Ferguson* (1962), 48 M.P.R. 155 at 169 (P.E.I. S.C.) was referred to in this regard.

d. Marriage

Marriage is a form of contract and requires that the decision maker understand the nature of the contract and the duties and responsibilities that it creates.

Marriage - Case Law

Marriage requires that an individual entering into this relationship have a level of capacity that is commensurate with that required to enter into comparable contractual agreements.

In *Re Capon; Capon and O'Brian v. McLay*¹⁶¹ the Ontario Court of Appeal stated that marriage "is essentially a civil contract and capacity and consent are indispensable requisites to its creation" and referred to the test laid down by Singleton, L.J., in *Re Estate of Park*¹⁶² as being applicable:

Was the deceased on the morning of May 30, 1949, capable of understanding the nature of the contract into which he was entering, or was his mental condition such that he was incapable of understanding it? To ascertain the nature of the contract of marriage a man must be mentally capable of appreciating that it involves the responsibilities normally attaching to marriage. Without that degree of mentality, it cannot be said that he understands the nature of the contract.

In *Deal v. Deal*¹⁶³ the Court dealt with an action for annulment of a marriage on the basis of incapacity from mental illness. After reviewing the facts in the case, Cowan J. cited *Re Park* as authority for the proposition that it "is well settled that the burden rests upon the petitioner to prove that a marriage, regular in form was, in fact, invalid through the incapacity of the respondent to consent to it." In the course of reviewing the origins of the applicable law, the Court quoted the following passage from *Durham v. Durham*:¹⁶⁴

I accept for the purposes of this case the definition which has been substantially agreed upon ... namely a capacity to understand the nature of the contract and the duties and responsibilities which it creates. It is to be observed, however, that this only conceals for a moment the difficulties of the inquiry, for I have still to determine the meaning to be attached to the word "understand". If I were to attempt to analyze this expression, I should encounter the same difficulties at some other stage of

¹⁶¹ (1965), [1965] 2 O.R. 83 (C.A.).

¹⁶² (1953), [1953] 2 All E.R. 408, affirmed [1953] 2 All E.R. 1411. For further discussion of this case, see Appendix III.

¹⁶³ (1966), 60 D.L.R. (2d) 411 (N.S. S.C.).

¹⁶⁴ (1885), 10 P.D. 80 at 81-82.

the investigation with reference to some other phrase, and I should still have to determine, on a review of the whole facts, whether the respondent came up to the standard of sanity which I must fix in my own mind, though I may not be able to express it. I may say this at the outset, that it appears to me that the contract of marriage is a very simple one, which does not require a high degree of intelligence to comprehend. It is an engagement between a man and a woman to live together, and to love one another as husband and wife, to the exclusion of all others. This is expanded in the promises of the marriage ceremony by words having reference to the natural relations which spring from that engagement, such as protection on the part of the man and submission on the part of the woman. I agree with the Solicitor General, that a mere comprehension of words of the promises exchanged is not sufficient. The mind of one of the parties may be capable of understanding the language used, but may yet be affected by such delusions, or other symptoms of insanity, as may satisfy the tribunal that there was not a real appreciation of the engagement apparently entered into ...

The Court decided that in such a proceeding, the burden rests on the petitioner to show, on a preponderance of credible evidence, that the marriage was invalid through the incapacity of the respondent to consent to it.¹⁶⁵ It noted that the test of such incapacity is whether the respondent was capable of understanding the nature of the contract into which she was entering and appreciating the responsibility normally attaching to marriage. In this case the Court found that the onus was not discharged by the evidence that the respondent, though committed to a mental hospital a few years after the marriage ceremony for schizophrenic psychosis, was, at the time of the marriage ceremony, merely a quiet, hypersensitive and shy person who, shortly after the marriage ceremony, conducted herself in a way that was as consistent with laziness as with inability to appreciate the normal responsibilities of marriage. This conclusion was buttressed by the inability of the psychiatric experts, called as witnesses on the petitioner's behalf, to say that it was not possible to say when the actual schizophrenic illness began.

In *Webb v. Webb*¹⁶⁶ Cowan J. considered another petition, this time by the wife, for a decree of nullity on the basis that the respondent husband was mentally incapable at the time of the marriage. After reviewing the facts and the applicable law, as was set out in *Deal v. Deal*, Cowan J. stated:¹⁶⁷

I am of the opinion, however, that ... the respondent was mentally capable of appreciating the nature of the contract of marriage and that it involved the responsibilities normally attaching to marriage. The evidence before me indicates that the respondent understood the responsibilities ... but it may be that, because of his mental condition, he was less able than some other persons to discharge fully those responsibilities. The witnesses who gave it as their opinion that the respondent was not capable of understanding the nature of the contract he was entering into and the responsibilities normally flowing

¹⁶⁵ The Supreme Court decision in *Smith v. Smith* (1952), [1952] 2 S.C.R. 312, 3 D.L.R. 449 was cited as authority for use of the civil standard of proof.

¹⁶⁶ (1968), 3 D.L.R. (3d) 100 (N.S. Divorce and Matrimonial Ct.).

¹⁶⁷ *Ibid* at 114-115.

from that contract, seemed to me to be having regard more to the capacity and ability of the respondent to discharge the responsibilities, rather than his capacity to appreciate the responsibilities which flow normally from the marriage contract.

In *Thompson v. Thompson*¹⁴⁸ the plaintiff had agreed to marry while suffering from depression and claimed that duress vitiated the validity of the consent that she had given during the marriage ceremony. However, since the depression had not impaired her ability to understand the nature of the marriage contract that she was entering into, her situation did not meet the requirements for annulment to be issued on the grounds of duress.

In *Re McElroy*¹⁴⁹ the surrogate court was faced with challenges to a will made a week before the testator's death, and to the validity of the marriage which had been solemnized two days before his death. The suspicious circumstances surrounding the preparation and execution of the will served to highlight the requirement that the applicant prove that the will was a voluntary act of a sound and disposing mind and memory. In this case the conscience of the Court was not so satisfied and the will was not admitted to probate.

Following this determination the surrogate court was then required to consider the testator's capacity to marry as a valid marriage would, by operation of law, have revoked the earlier will. Honsberger Surrogate Court Judge referred to *Re Park* and to the requirement stated therein that the individual be "capable of understanding the nature of the contract he was entering into, free from the influence of morbid delusions on the subject" as being the applicable test. In this case it was decided that the deceased did appreciate the duties and responsibilities which marriage created and was mentally capable of understanding the contract into which he was about to and did enter. In this case, the placing of the onus on the party asserting the invalidity of the marriage was clearly a major factor in the determination that, although the will could not be admitted to probate by reason of a lack of testamentary capacity, the testator nonetheless retained the requisite capacity to marry.

¹⁴⁸ (1971), 19 D.L.R. (3d) 608 (Sask. Q.B.).

¹⁴⁹ (1978), 22 O.R. (2d) 381, 93 D.L.R. (3d) 522.

3. Capacity to Select a Substitute Decision Maker

Individuals should be able to understand the nature of the decisions that will be made by the substitute decision maker and the nature of their relationship with the proposed substitute. Although the issues raised by the selection of a substitute fall outside the scope of this report, concerns about potential conflicts of interest such as those which would result from the appointment of a care giver, advocate or administrator as a substitute could, in addition, influence the assessment of the individual's capacity. We recommend that persons in such relationships with an individual should only be allowed to serve as the substitute decision maker for the individual under formal legal supervision.

Review of Statutory and Case Law Developments

Please see the relevant statutory provisions that are reproduced in the Appendices.

Case Law Developments

While the possibility of appointing a "patient representative"¹⁷⁰ or a so-called "durable" power of attorney¹⁷¹ are relatively recent innovations and the courts have not, to our knowledge, had occasion to elaborate on the capacity that is required in order for an individual to appoint such a substitute, the courts have addressed this question with respect to the appointment of a traditional power of attorney and would appear to state principles that should be equally applicable to the more modern forms of substitutes.

In *McEwen v. Jenkins*¹⁷² the Supreme Court considered allegations that the testator/donor of a power of attorney lacked the capacity to execute either of these instruments. In coming to the conclusion that the giver of these instruments was incapable, the Court stated the rule that a disposing mind and memory is one that is able to comprehend, of its own initiative and volition, the essential elements of the transaction. In this case the Court found that the proponents of the will and the power of attorney had not established that the deceased had possessed the

¹⁷⁰ Under s.1b of the Ontario *Mental Health Act* as amended by S.O. 1987, c.37, s.2.

¹⁷¹ One that will survive the incapacity of the donor. See the provisions of the Ontario *Powers of Attorney Act*, R.S.O. 1980, c.386 (as amended) reproduced in the Appendices.

¹⁷² (1958), [1958] S.C.R. 719.

necessary mental abilities to allow him to comprehend the effect and the consequences of the acts he performed. It had been shown that the deceased's mind was, at the relevant times, habitually in a state of confusion, incapable of discernment, and no satisfactory evidence was adduced to support the proposition that the instruments were executed during periods of lucid intervals.

In *Hrycan Estate v. Hrycan*,¹⁷³ as in *McEwen v. Jenkins*, the Court was dealing with a challenge to the validity of both a will and a power of attorney. The Court reviewed the law on the subject of testamentary capacity and after quoting from *Leger v. Poirier*, *Banks v. Goodfellow* and a number of other cases on this subject, concluded that it was "satisfied that the will (power of attorney) executed by Sophie Hrycan on February 18, 1982, expresses her mind at a time when she undoubtedly had testamentary capacity". The holding in this case suggests that either the test for the capacity to execute a power of attorney is the same as that of testamentary capacity, or that it is similar, albeit less onerous. Given the similarities between the two types of instruments, and the fact that they were often executed at the same time and in favour of the same individual, the use of the same test would seem to make sense under the circumstances. These cases leave the question of onus unresolved and while the tie in, in these cases, to the requirements for testamentary capacity suggest that the onus should be borne by the individual asserting the validity of the power we do not feel that this should be true as a general proposition and would favour the onus being borne by the party asserting incapacity in all cases involving the appointment of a substitute.

4. Capacity to Make Decisions Regarding Information Disclosure

The decision maker should be able to understand his/her right to control disclosure, the nature of the information to be disclosed, the nature of the party to whom it is to be disclosed, the reason that the disclosure has been requested, and the likely consequences of its disclosure in the manner in question.

Review of Statutory and Case Law Developments

Please see the relevant statutory provisions that are reproduced in the Appendices. Worthy of note are the provisions of the *Mental Health Act* which have relatively recently been amended¹⁷⁴ to reflect increasing awareness that

¹⁷³ (1986), [1986] S.J. No. 534 (Q.B.).

¹⁷⁴ See in particular ss.29 and 29a.

patients have *prima facie* rights both to the confidentiality of information about them and to access and review their clinical records.¹⁷⁵

Case Law Developments

The capacity to consent to the disclosure of health care records must be seen in the broader context of the common law and statutory requirements for confidentiality and disclosure which govern medical professionals in this regard.¹⁷⁶ In Ontario, the provisions of the *Mental Health Act*, quoted in the Appendices, provide extensive guidance with respect to this subject, but beyond the general definition of competency in s.1(g) do not provide guidelines for the assessment of capacity to consent to the disclosure of medical records. To the best of our knowledge, the courts in Ontario have not yet been asked to rule on this subject.¹⁷⁷ The courts have, however, recognized that "a patient, or the personal representative of a deceased patient, has something akin to a proprietary interest in the contents of the medical records" and that a hospital should not employ the discretion granted it by the *Hospital Act* to prevent the inspection of the record.¹⁷⁸

¹⁷⁵ These changes reflecting increased awareness of individual rights and the recognition of these rights in the case law. For example see *Lindsay v. M.* (1981), 121 D.L.R. (3d) 261 (Alta. C.A.). For further discussion of this case, see Appendix V.

¹⁷⁶ The subject of patients' rights with respect to medical records was investigated by the Honourable Mr. Justice Horace Krever who in 1977 was appointed under the *Public Inquiries Act*, S.O. 1971, c.49, s.6(1), to conduct an inquiry into the confidentiality of health records in Ontario. The report of the Commission has provided the basis for current legislative provisions and safeguards on this subject. The Commission was primarily concerned with the abuses of confidentiality provisions that were evident in hundreds of cases of improper disclosure of medical information to members of the Royal Canadian Mounted Police from physicians and hospital employees in Ontario. The work of the Commission gave rise to a legal dispute over whether or not the identity of the doctors and hospital employees who had disclosed medical records were protected by a police informers privilege, see *Re Inquiry into the Confidentiality of Health Records in Ontario* (1978), 21 O.R. (2d) 402, 90 D.L.R. (3d) 576 (Div. Ct.), appealed (1979), 98 D.L.R. 9(3d) 704 (C.A.), appeal to the Supreme Court of Canada allowed (1981), 38 N.R. 588.

¹⁷⁷ Most cases dealing with the disclosure of medical records concern disputes over the access to this information for use in support of litigation. For example see *Re L.* (1981), [1981] O.J. No. 1 (Co. Ct.) in which the court discussed the balancing of the provisions of the *Mental Health Act* which limit the disclosure of records to protect the patient against the interests of justice that arose out of one of the party's desire to be able to adduce this information as evidence in Court. See also *R. v. Worth* (1989), [1989] O.J. No. 1301 (H.C.) which involved an unsuccessful application to quash search warrants requesting the records of the former psychiatric patient from the mental health systems in three provinces for use in a murder prosecution.

¹⁷⁸ See *Re Mitchell and St. Michael's Hospital* (1981), 29 O.R. (2d) 185, 112 D.L.R. (3d) 360 (H.C.) referring to the discretion granted the hospital under the *Public Hospitals Act*, R.S.O. 1980, c.410, s.11. For further discussion of this case, see Appendix V. See also *Strazdins v. Orthopaedic & Arthritic Hospital Toronto* (1978), 22 O.R. (2d) 47, 7 C.P.C. 243, 7 C.C.L.T. 117.

F. REVIEW OF CRITERIA EMPLOYED IN DECISIONAL CONTEXTS - SUMMARY

Tests of capacity must reflect the specific functional requirements of the decision that is to be made in each case. The statutory instruments and court decisions reviewed above serve to highlight many of the issues and tensions that underlie the specification of criteria for the assessment of capacity. The most fundamental conflict is that between the promotion of autonomy, as opposed to the best interests of the individual. Notable in this regard is the extent to which the courts were ready to intervene to prevent the occurrence of what they determined to be an undesirable outcome. The balance between the consideration of the process by which a decision was made, as opposed to the probable outcome, seems to have been drawn by judges in light of all the circumstances of each case and has demonstrated the common law's tendency to favour a "reasonableness" based approach. In a number of the common law decisions the interpretation of the requirements for "understanding" and "appreciation" appear to be informed by the context and are set higher with respect to decisions that may be tainted with concerns about undue influence or other such factors than they would be in the absence of such concerns. The courts appear to have been wrestling with all of the issues that were outlined in the earlier discussion of relevant factors and in addition have also discussed, but not reached any conclusions about, the relative merit of lay as against expert witness evidence.¹⁷⁹

In conclusion, it is apparent that the common law has not been able to resolve, with any measure of clarity, the underlying conflicts and in particular the weight to be given the evidence of the process as against that of the outcome. The courts have generally seemed unwilling to recognize as valid any decision that they perceived as clearly unreasonable and in this way may be seen as requiring that the decision maker conform with a socially informed view of reality. As was demonstrated in *McKay v. O'Doherty*,¹⁸⁰ the requirement for "appreciation" under the *Mental Health Act* has been interpreted as dictating a similar measure of social conformity insofar as the court required that the patient accept his or her diagnoses before he or she could be considered capable of appreciating the consequences of giving or withholding consent. The so-called delusional individual presents the most intractable dilemma to an assessor of capacity insofar as the individual's alleged

¹⁷⁹ In particular the differing views of the majority and dissent in *Re Schwartz* (1970), [1970] 2 O.R. 61 serve to highlight this debate. For further discussion of this case, see Appendix III.

¹⁸⁰ (1989), [1989] O.J. No. 965.

incapacity arises out of his or her refusal or inability to perceive the world in the socially agreed fashion. For this reason, we propose that this category of individual must be accorded special recognition and procedural safeguards so as to ensure that the assessment of capacity is not employed to enforce social conformity by such individuals.

G. CATEGORIES OF DECISION MAKERS

1. Mentally Disordered

The mentally disordered are those individuals who by thought, expression or conduct have evidenced symptoms of mental illness in accordance with the definitions prescribed by law.

Important Parameters

The following are parameters for assessing mental illness and are derived from the mental status examination: thought content (delusional ideation, suspiciousness, guardedness, quantity of a client's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (client's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of mood).

Vulnerabilities or Relevant Special Characteristics

The tendency to conflate mental illness with lack of capacity, which occurs to an even greater extent when involuntary commitment is involved, has deep historical roots, and even though changes have occurred in the law over the past twenty years, attitudes and beliefs have been slow to change. For this reason it is particularly important that autonomy and self determination be given priority when assessing individuals in this group.

2. Developmentally Handicapped

The term developmentally handicapped refers to those individuals classified as having a developmental handicap, which means a condition of mental

impairment present or occurring during a person's formative years, that is associated with limitations in adaptive behaviour.¹⁸¹

Important Parameters

The developmentally handicapped condition is assessed by examining the following: cognitive functioning which consists of sensorium (primarily consciousness and orientation), memory and intellectual tasks, the latter includes fund of knowledge, counting, calculation and insight. The irreversibility of the underlying condition is an important concern and highlights the need for appropriate training to achieve maximum developmental potential.

Vulnerabilities or Relevant Special Characteristics

The tendency to conflate developmental handicap with lack of capacity to make decisions has a similar history to that described above for mental illness. Such individuals are susceptible to this stigma, notwithstanding whether or not they have been institutionalized. As with the mentally disordered, over the past few years efforts have been made to emphasize autonomy and self determination for this group, but these efforts have met with considerable societal resistance.

3. Geriatric Patients

Individuals 65 years of age or over who suffer from a medical condition fall into this category. We are particularly interested in patients suffering from a physical condition which may have physical, mental, behavioral or emotional manifestations even though we recognize that this category includes those suffering from functional mental illnesses.

Important Parameters

Traditional elements of the mental status exam are applicable to the assessment of the geriatric population: thought content (delusional ideation, suspiciousness, guardedness, quantity of a patient's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (patient's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of

¹⁸¹ *Developmental Services Act*, S.O. 1974, c.2, s.1(c).

mood). Self protectiveness, sedimented preferences, social functioning (ability to care for self and make appropriate social decisions), weighing of parameters in a manner that reflects the functional requirements of the individual's life circumstances. In light of the above, an unexplained change in decisional patterns may be particularly significant for members of this group.

Vulnerabilities or Relevant Special Characteristics

The geriatric population are prone to being stereotyped as senile and therefore incapable. A lack of financial resources, diminished physical strength and the absence of adequate support systems often serves to prevent individuals in this group from affirming their rights. The tendency for members of this population to be considered socially marginal and treated as incapable must be consciously countered.

A more detailed discussion on the topic of senior citizens and mental capacity is given in Chapter XII of this report.

4. Minors

The class of minors includes infants, children and adolescents all of whom are characterized as incapable for various functions. This is conceptually problematic because our knowledge of developmental psychology suggests that moral mindedness occurs in most by early adolescence.

Important Parameters

Developmental parameters which are primarily concerned with notions of insight and judgment are frequently used to justify the presumption of incapacity in minors. The perceived susceptibility of minors to external influences is put forward as evidence of minors' lack of good judgment.

The existence of socially validated substitute decision makers (parents, legal guardians, etc.) is often referred to as a parameter. Thus, the "emancipated" or married minor will be recognized as capable when similar individuals living in their parent's home will not be. Social policy exceptions such as those for treatment of sexually transmitted diseases, drug abuse, birth control counselling and abortion are further evidence that capacity determinations in minors reflect primarily social and not functional concerns.

Vulnerabilities or Relevant Special Characteristics

Minors are generally under the complete physical and financial control of their parents or guardians and are recognized as being in need of comparable protection in the absence or breakdown of the traditional family structure.

A more detailed discussion on the topic of decision making by children and adolescents is given in Chapter XI of this report.

5. Medical Patients

Medical patients refers predominantly to inpatients suffering from both acute and chronic illnesses. Particularly vulnerable groups include those under close observation and control such as seriously ill patients in intensive care or coronary units, and patients in long term care facilities or those who are otherwise immobilized and confined.

Important Parameters

Medical patients are evaluated by examining the following: thought content (delusional ideation, suspiciousness, guardedness, quantity of a patient's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (patient's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of mood). Patients' preferences in light of life circumstances need to be given special consideration.

Vulnerabilities or Relevant Special Characteristics

Patients in this state may be vulnerable to physical or mental coercion and may be susceptible to physiologically based impairments of cognitive processes.

6. Terminally Ill

These are individuals afflicted by an incurable condition caused by disease, injury, or illness. Regardless of life sustaining procedures, this condition would, according to reasonable medical judgment, result in death. In such circumstances the application of life sustaining procedures serves merely to postpone the eventuality of the patient's death.

Important Parameters

Thought content (delusional ideation, suspiciousness, guardedness, quantity of a patient's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (patient's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of mood). The patient's preferences should be accorded special status.

Vulnerabilities or Relevant Special Characteristics

Lack of power and control over life circumstances.

7. Prisoners

Inmates held in prison and detention systems may be subject to a number of forces which may bear on their apparent capacity.

Important Parameters

The following parameters are used to evaluate prisoners: thought content (delusional ideation, suspiciousness, guardedness, quantity of a client's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (client's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of mood).

Vulnerabilities or Relevant Special Characteristics

There is a particular tendency in those individuals confined against their will for extended periods of time to become highly dependent. This characteristic would render them susceptible to external influences that may work against their personal interests. Furthermore, especially in the case of human experimentation, the possibilities of secondary gain from participation might preclude truly voluntary participation in such programs.

8. Research Subjects

This group can include members of any of the above classes as well as other members of society.

Important Parameters

Research subjects are evaluated by the following: thought content (delusional ideation, suspiciousness, guardedness, quantity of a client's ideas); thought process (volume of thought, flow, coherence, relevance, logic, blocking, neologisms); hallucinations (client's perception); cognitive abilities (sensorium, memory, intellectual tasks - includes judgment and insight); mood and affect (intensity, duration, fluctuation of mood).

While there must always be full and complete disclosure as required under the informed consent doctrine, a somewhat more stringent standard should be adhered to when the research involves individuals who do not stand to benefit therapeutically from the procedure that they are consenting to.

Vulnerabilities or Relevant Special Characteristics

The use of members of vulnerable groups for experimentation requires strict supervision and regulation, particularly where there is no benefit expected to accrue to the subject.

H. CATEGORIES OF DECISION MAKERS - SUMMARY

Formal assessment of capacity should take into account the important parameters and vulnerabilities of special characteristics of the individual under assessment and must as well be performed in a manner that sensitively reflects the cultural and social concerns that were previously enumerated.

XI. DECISION MAKING BY CHILDREN AND ADOLESCENTS

A. LEGAL ADULTHOOD AND THE ROLE OF THE FAMILY

In 1989, the mandate of the Enquiry was expanded to include issues of competence as they relate to children. Children's issues differ from general issues regarding competence because of the child's position in a family, the social institution generally being viewed as the guardian of the best interests of the child. It is not that the family is irrelevant to adults who are of marginal competence; it is rather that adulthood is generally seen to include the right to be an individual, free of family control. The issue is whether and at what point this right is to be extended to persons who are not yet adults.

Adulthood is a legally nebulous concept at best. The law recognizes the reality that children are capable of different decisions at different ages, and the rights of an individual accrue gradually as the child grows up. Individuals became liable under criminal law at the age of seven.¹⁸² Liability for damages in tort may commence as early as age six or seven, if the child did not exercise the standard of care expected of a person of the child's age, and a child engaging in "adult-like activities" will have the same civil liability as an adult engaging in such activities.¹⁸³ Commencing at age seven, a child's consent in writing is required prior to the child being adopted.¹⁸⁴ At age twelve, they may attend a cinema presentation after 7:30 p.m. or during school hours. At age fourteen, they are required to consent to any application to change their name. Individuals are required to attend school until the age of sixteen. At that age they are also eligible to apply for a driver's licence, and to marry if their parents consent. At common law and old statute law, sixteen was also the age at which the courts would refuse to require a child to return to his or her parents' house. The attainment of the age of eighteen years carries with it a panoply of rights and privileges: the individual may vote, may purchase tobacco, may serve as a corporate director, may make a will,¹⁸⁵ may sue in his or

¹⁸² This has been modified by statute to the age of twelve years: see *Young Offenders' Act*, R.S.C. 1985, c. Y-1 and *Criminal Code*, R.S.C. 1985, c.C-42, s.13. Until the age of sixteen, the individual is to be tried in a special youth court; for individuals aged sixteen or seventeen, application can be made to the judge to have the individual tried in adult court.

¹⁸³ See J. Wilson and M. Tomlinson *Children and the Law*, (2nd ed.), (Toronto: Butterworths, 1986) at 297. The parents may in some circumstances be liable for the acts of a child under six or seven years of age, but the child himself or herself cannot be personally liable for the damages.

¹⁸⁴ See *Child and Family Services Act*, S.O. 1984, c.55, s.131(6).

¹⁸⁵ A married child under the age of eighteen may also make a will.

her own name, and acquire full contractual rights. Alcohol may be purchased and consumed commencing at the age of nineteen years. Twenty-one is no longer an important threshold of adulthood, although it remained the age of consent for some sexual activity until 1989.

Twenty-one years was the so-called "age of majority" for centuries and until well into the twentieth century. It does not appear that there was anything particularly significant regarding mental development in the choice of twenty-one years. Rather, it would appear that the age corresponded to the right and ability to bear arms, and age twenty-one was when men became strong enough to wear the heavy medieval armour.¹⁸⁶ The age has been lowered by statute in all Canadian provinces, generally to eighteen years. This change occurred in Ontario with the enactment of the *Age of Majority and Accountability Act* in 1971.¹⁸⁷

The legal recognition of family rights and obligations to children is similarly nebulous. For our purposes, the family may generally be understood as the parents of the child; there is little consideration in law given to the rights of the extended family. In general, the law recognizes the right of parents to the care and custody of their children. The courts have recognized the power of the state to intervene in the care of children since at least the early eighteenth century,¹⁸⁸ but in recent times this power has not been exercised absent compelling circumstances such as child neglect. Unlike the situation with an incompetent adult, no court appointment is necessary for the parent to make personal guardianship decisions on behalf of a child.¹⁸⁹

¹⁸⁶ L.H. Glantz, G.J. Annas and B.F. Katz "Scientific Research with Children: Legal Incapacity and Proxy Consent". (1977) 11 *Family Law Quarterly* 235; cited by L. Weithorn "Involving Children in Decisions Affecting their Own Welfare". In G. Melton, G. Koocher and M. Saks (eds.), *Children's Competence to Consent*, (New York: Plenum Press, 1983) at 239.

¹⁸⁷ S.O. 1971, c.98, consolidated as R.S.O. 1980, c.7.

¹⁸⁸ See *Shaftsbury (Earl of) v. Shaftsbury* (1725), Gilb. Rep. 172. The court in this case refers to *Freeman v. Bishop of Oxford* (1719) and *Vernon's Case* (1723-24) as authority for the court's *parens patriae* jurisdiction regarding children. The *Shaftsbury* case does not explain what the controversy was regarding the child at issue; both the cases cited in support concerned the child's education. In the *Freeman* case, the court intervened to transfer the child from Oxford to Cambridge University. In *Vernon*, the child was ordered to be transferred to Eaton School. It is difficult to imagine the court exercising its *parens patriae* power in similar circumstances today. For further discussion of the *Shaftsbury (Earl of) v. Shaftsbury* case, see Appendix III.

¹⁸⁹ For a recent authority on this point, see *Re Eve* (1986), 13 C.P.C. 6 (S.C.C.). For further discussion of this case, see Appendix II and Appendix IV.

While parents are recognized at common law as having personal guardianship rights over their children, no civil law duty to care for the child arose at common law.¹⁹⁰ Presumably in response to this, the Ontario legislature enacted the *Children's Maintenance Act* in 1931.¹⁹¹ This statute created a civil duty to "maintain and educate" one's children until they had reached the age of sixteen years. Section 4 of the *Act*, however, limited the duty:

4. Nothing in this *Act* shall be construed as compelling any special remedial treatment for a child contrary to the objection of the parent, guardian or person acting *in loco parentis*.

While the point does not appear to have been tested in a court, it would appear that this section was understood to preclude the imposition of a civil duty as regards the provision of medical treatment to a child.

The *Children's Maintenance Act* was amended in 1971 to include a duty to support and educate children aged sixteen or seventeen who were in full-time attendance at an educational institution. In 1978, the support provisions were included in the *Family Law Reform Act* without the equivalent of clause 4, cited above. The provisions are reflected now in the following provision of the *Family Law Act*:

- 31 (1) Every parent has an obligation to provide support, in accordance with need, for his or her unmarried child who is a minor or is enrolled in a full time program of education, to the extent that the parent is capable of doing so.
- (2) The obligation under subsection (1) does not extend to a child who is sixteen years of age or older and has withdrawn from parental control.¹⁹²

¹⁹⁰ *Childs v. Forfar* (1921), 67 D.L.R. 17; 51 O.L.R. 210. The issue arose most frequently in collection actions against the parent for services provided to the child. The court recognized a strong moral duty on the parent to provide for the child, and thus was inclined to enforce payment against the parent when even a weak basis to do so could be identified: see for example *St. Catharines General Hospital v. Sviargula*, [1961] O.R. 164 (H.C.), where an undertaking by a father to pay "as much as he could when he could" was held to create an enforceable agreement between the father and the hospital. Without some representation, however, such a debt was unenforceable; the common law did not create in itself a duty to pay flowing from the relationship between parents and children.

In addition, recall that the failure of a parent to provide for a child could result in the invocation of the state's *parens patriae* jurisdiction regarding the child, and the removal of parental authority over the child. In some circumstances, it might also result in criminal charges: see below.

¹⁹¹ S.O. 1931, c.34.

¹⁹² S.O. 1986, c.4, s.31. The *Family Law Act* also requires children to support their parents, to the extent that they are able to do so.

The civil responsibility which attaches can be seen as largely a financial responsibility. This is consistent with the fact that the special provisions for "remedial treatment" have been deleted: with the advent of socialized health care, medical treatment no longer presents the financial threat it did in the 1930s, when the *Children's Maintenance Act* was passed.

The criminal law provides that parents and persons *in loco parentis* are required to provide necessities of life to children under the age of sixteen years.¹⁹³ The denial of adequate medical treatment by a parent for his or her child will attract criminal liability under this section only if the treatment is necessary to preserve life. The failure to provide such treatment, however, could make the parent guilty of death by criminal negligence in the event that the failure to provide the treatment accelerates the child's death.¹⁹⁴

In sum, the law certainly recognizes the relationship between parents and children, therefore, and absent compelling circumstances for the removal of parental authority, grants certain decision making rights to the parents. The responsibility imposed on parents beyond the financial responsibility to raise and educate their children is limited to the criminal responsibility to provide necessities.

In the event that the parent does not meet a certain standard of care, the state may, of course, remove the children from parental control. The authority to do so under the *Child and Family Services Act* ceases when the child becomes sixteen years of age.¹⁹⁵ Even in these cases of child protection, however, the state continues to recognize the importance of family ties. Access rights are normally provided to the parents, and the parents' financial responsibility continues. It is only upon adoption of the child that the ties with the child's birth family actually cease.

The substantive decision making powers of parents are prescribed by common law, and in general may be summarized as encompassing decisions related to custody and control of the child. Parents are presumed in law to be the natural personal guardians of their children, as they are presumed to act in the best interests of their children. No court appointment is necessary prior to the exercise of such personal guardianship. To keep this authority, however, the parents are

¹⁹³ *Criminal Code*, R.S.C. 1985, c. C-42, s.215(1).

¹⁹⁴ See *R. v. Cyrenne, Cyrenne and Cramb* (1981), 62 C.C.C. (2d) 238 (Ont. Dist. Ct.).

¹⁹⁵ s.37(1)(a).

required to act in what the common law understands to be the "best interests" of the child. In this, the authority of the parent is the same as the authority of a court-appointed guardian for a mentally incompetent adult. The two leading cases regarding the scope of authority of a guardian in medical treatment are *Superintendent of Family and Child Service v. R.D. and S.D.*¹⁹⁶ [the Dawson case], and *Re Eve*.¹⁹⁷ Both these cases are somewhat extreme on their facts, but they provide an indication of the scope of parental authority.

The Dawson case involved an infant with respiratory problems who, as a result of spinal meningitis, was also severely developmentally and physically handicapped. The attending physician recommended a shunt operation, which gave Dawson a reasonable chance at survival, but would not have solved his handicaps. Without the shunt, Dawson could have been subjected to increasingly disabling pain. His parents refused consent to further medical treatment, preferring to allow their child to "die in peace". An application was made concerning Dawson under the British Columbia child protection statute. The court held that the treatment should be performed. The court further held that no distinction was to be made between the life of a handicapped child and that of a "normal" child, and that the lives of all children were worth preserving. The court consented to the treatment. From this case, it is to be understood that when relatively routine surgical intervention is involved, consent to life-saving treatment is virtually always in the best interests of the child. Whether this rule extends to extraordinary treatment required to keep a child alive is not yet clear.¹⁹⁸

The *Eve* case involved a developmentally handicapped adult. Eve's doctors wished to preclude the possibility that she would become pregnant, and therefore requested consent to a non-therapeutic sterilization of Eve. Eve's parents applied to the court to determine whether they had jurisdiction to consent to this operation. The case proceeded to the Supreme Court of Canada, where it was decided that the parents did not have this jurisdiction. The court reasoned as follows:

Though the scope or sphere of the operation of the *parens patriae* jurisdiction may be unlimited, it by no means follows that the discretion to exercise it is unlimited. It must be exercised in accordance with its underlying principle. Simply put, the discretion is to do what is necessary for the protection

¹⁹⁶ (1983), 42 B.C.L.R. 173 (B.C.S.C.). For further discussion of this case, see Appendix IV.

¹⁹⁷ (1986), 13 C.P.C. (2d) 8 (S.C.C.). For further discussion of this case, see Appendix II and Appendix IV.

¹⁹⁸ In the *Eve* case, the court specifically does not decide this point: see 13 C.P.C. (2d) 6 (S.C.C.) at 38. For further discussion of this case, see Appendix II and Appendix IV.

of the person for whose benefit it is exercised ... The discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be particularly so in cases where a Court might be tempted to act because failure to do so would risk imposing an obviously heavy burden on some other individual.¹⁹⁹

The court eventually held that non-therapeutic sterilization could never be authorized by a substitute, as it would never be in the legal best interests of the patient, but the reasons cited above are broader than that. The only interests to be considered are those of the incompetent person. The fact that a child may be wreaking havoc within a family, causing pain to all other family members is presumably not to be considered when deciding whether the child is to be treated. As in the United States,²⁰⁰ a parent in Ontario could presumably not consent to an organ transplant from one child to its sibling, who might die without the transplant, as this bears no benefit for the donating child.²⁰¹ Thus it is clear that on one hand the law recognizes the family as providing a framework in which substituted decision makers are generally selected, thus providing some legal status to the family relationship, nonetheless, it is also clear that when a family value conflicts with the interests of the child as very narrowly defined, the interests of the child are to hold sway. For valid consents to these procedures to be given, they must be given by the capable minor.

Interestingly, nothing precludes children from owning property, although as we shall see below this privilege may not be a practical option as they are likely to be precluded from executing contracts regarding their property. Parents are not in law automatically the trustees of their children's property. To be appointed trustee for a child's property, the parent must seek a court appointment under the *Children's Law Reform Act*.²⁰² These appointments are subject to court supervision, and court orders may be necessary for major transactions involving the property of the child following such an appointment, if the guardian is not to be held responsible for the transaction.

¹⁹⁹ At 40. For further discussion of this case, see Appendix II and Appendix IV.

²⁰⁰ *Strunk v. Strunk*, 445 S.W. 2d 145 (Ky., 1969).

²⁰¹ Similarly, it is at best dubious whether a parent could consent to any form of medical research involving the child whether or not that research posed any risk to the child, unless there were a concrete benefit flowing to the child as a result of the research.

²⁰² R.S.O. 1980, c.68. The *Act* does contain the exception that persons owing relatively debts of less than \$2,000 per annum, to a total maximum of \$5,000 may discharge the debt by paying the amount to the custodial parent of the child.

B. THE DECISIONAL CAPACITY OF CHILDREN

As discussed above, the law recognizes the advent of adulthood at various stages in the child's life. Authority for decisions relevant to the Enquiry are partly a function of common law, partly statute law, and partly, perhaps, regulation.

A child's ability to deal with his or her estate is dependent on the content of the estate.²⁰³ For example, a child who is legally able to work is entitled to his or her own wages.²⁰⁴ Children may receive gifts outright, but generally gifts from children must be ratified by the child upon reaching the age of eighteen years in order to be valid. Children also have rights under the *Succession Law Reform Act* to support from the estates of their parents, although applications under this *Act* are generally teamed with an application to appoint a guardian under the *Children's Law Reform Act*, so that it would be rare that a child would be directly responsible for an estate received in this way.

While nothing precludes a child from owning property, possession of a sizable estate may nonetheless not be practicable for a child because of restrictions on ability to contract. In general, full contractual rights are only attained at age eighteen, but contracts executed by minors are nonetheless not automatically nullities. The first issue for consideration by the court is whether the contract at issue is prejudicial to the interests of the minor. If it is, it is utterly void. The fact that a contract may include a clause which is standard in dealings between adults does not mean that the clause will not be found prejudicial to the interests of the minor, rendering the entire contract void and unenforceable.²⁰⁵ This overriding rule is consistent with the principle laid down in *Eve*, that the *parens patriae* jurisdiction is to be exercised to protect the incompetent person.

Minors may nonetheless contract for necessities of life, as long as these contracts are not prejudicial to their interests. What constitutes a "necessary" will depend on the circumstances, including the minor's age, needs, degree of emancipation, and standard of living. It could include a car, for example, if

²⁰³ With respect to capacity to manage one's estate, we have relied heavily on J. Wilson and M. Tomlinson *Children and the Law*, (2nd ed.), (Toronto: Butterworths, 1986), chapter 5.

²⁰⁴ See *Haas v. Nyholm*, [1923] 3 W.W.R. 921 (Sask. Dist. Ct.), cited by J. Wilson and M. Tomlinson at 263.

²⁰⁵ See, for example, *Ivan v. Hartley*, [1945] 4 D.L.R. 142 (Ont. H.C.), where a chattel mortgage was declared detrimental to the interests of the minor because it included the standard clause regarding acceleration and repossession.

required for the minor's employment, but presumably not if the car were desired as a luxury item. In one case, a contract for the purchase of a house was upheld as the house was a necessary.²⁰⁶ This decision would suggest that other contracts for accommodation such as leases and rental agreements would also be enforceable. In addition, insofar as the provision of medical services continues to be within the realm of contract law, contracts for the provision of medically necessary services are also enforceable.²⁰⁷ The common law provision regarding the right to contract for necessities is also codified in the Ontario *Sale of Goods Act*.²⁰⁸

Minors may also generally be bound by employment contracts, assuming such contracts are beneficial to the child. The court will look to the wages paid and the terms used by other employers in determining whether the contract is beneficial to the child. The rule regarding employment contracts is an outgrowth of the rule regarding necessities: it is considered that employment provides wages, essentially a necessary as it provides the means of earning a living. Given this attitude, it is somewhat paradoxical that the law will not generally consider a contract for goods or services required for the child to conduct a business as a contract for necessities. This would appear to be because the minor is not considered to have sufficient maturity to run a business, a rather illogical assumption given that the child is considered mature enough to enter into employment contracts and contracts for services.

At common law, unless falling into one of these classes where the minor had the right to contract, contracts executed by minors were either void or voidable. A contract would be absolutely void, that is, of no legal force or effect, if the contract was found to be detrimental to the interests of the minor. By historical anomaly, debts contracted by a minor are voidable but must be ratified by the minor upon the attainment of the age of majority.²⁰⁹ Otherwise, a voidable contract is enforceable unless repudiated upon the minor reaching the age of majority. If the minor has received some advantage from the contract, however, the contract can be repudiated only upon the return to the other party of equivalent value to the advantage received.

²⁰⁶ See *Soon v. Watson* (1962), 33 D.L.R. (2d) 428.

²⁰⁷ See *Deziel v. Deziel*, [1953] 1 D.L.R. 651 (Ont. H.C.).

²⁰⁸ R.S.O. 1980, c.462, s.3.

²⁰⁹ See section 7 of the Statute of Frauds.

A number of statutes vary the common law rule that minors may not execute contracts. The *Apprenticeship and Tradesman's Qualifications Act*, for example, requires both parent and child to execute an apprenticeship agreement, if the child is between sixteen and eighteen years of age. Persons aged sixteen or more may enter life insurance contracts by virtue of Ontario's *Insurance Act*. The *Child and Family Services Act* contains a general provision that an individual is not incompetent to enter into the agreements prescribed in that *Act* merely because the individual has not attained the age of eighteen years.²¹⁰ That *Act* further provides a number of circumstances where individuals under the age of eighteen years must be parties to certain agreements. A child aged seven or more, for example, must consent to an application for his or her adoption.²¹¹ A temporary care agreement may not be concluded for a child who has attained the age of twelve years, unless the child is a party to the agreement.²¹²

Existing law does not prescribe any way for a person under the age of sixteen years to designate a substitute decision maker. The entire process of such designations is very new, existing only under the *Mental Health Act*, and then only since 1987. This was a rather radical departure from existing law which placed all persons becoming incompetent under the jurisdiction of the crown, which exercised absolute discretion in the appointment of a guardian or committee of the estate for the individual. The *Mental Health Act* provisions specifically require that the individual making an appointment be sixteen years of age or over.

In general, the Enquiry has not been informed of significant difficulties in the existing provisions regarding contractual capacity. What difficulties have been identified have generally referred to the desires of minors to leave parental control. The existing law does not preclude this option, as the minor is given the right to contract for necessities and to enter into contracts of employment. Restrictions on this ability are more the result of statutes restricting the rights of the minor in other ways than because of competency. The law restricts the ability of the work by requiring school attendance until the age of sixteen years, for example, and therefore in a sense restricts the ability of the minor to become self-sufficient. This policy does not stem from concerns of competency, however, but rather from a social policy favouring education.

²¹⁰ Section 4(4).

²¹¹ s.131(6).

²¹² s.29(2)(b).

Regarding access to medical care, the common law position for children, as for anyone else, is that treatment may be given only if a competent, informed and voluntary consent is obtained. Otherwise, a person providing treatment commits the tort of battery by touching the patient in an unwanted fashion. The law does not specify a specific age at which an individual becomes competent; the issue, as explained elsewhere in this report, is essentially whether the patient understands the nature of the treatment, and the consequences of giving or withholding consent. The legal guardian has the authority to consent to treatment for an incapable person, although such authority must be exercised in a manner that is consistent with the person's best interests, as discussed above.

The law presumes competence in adults, and there is no explicit rejection of such a presumption regarding children. In the leading Ontario case of *Johnson v. Wellesley Hospital*,²¹³ which occurred when the age of majority was still twenty-one, Justice Addy held that it would be absurd to find that a man in his late teens could not consent to be touched such as would provide a defence to a battery action. This decision would suggest that the presumption of competence is not destroyed merely because an individual has not attained the age of majority. However, it would be playing legal games to pretend that the court would apply the same presumption to a child of three as to an adult. While the legal doctrine may remain unchanged, the reality is that the presumption of competence is likely to be accorded more weight in proportion to the child's age. There is insufficient case law in this area to ascertain at what stage the presumption of competence becomes particularly important.

The common law has been varied in a number of ways. Section 1d of the *Mental Health Act* provides that persons under the age of sixteen years are presumed to be incompetent, but the presumption is rebuttable. The determination that an individual under the age of sixteen years is competent may be made by the attending physician, or alternatively, the individual may apply for a determination by the mental health review board. The presumption applies to the release of clinical records and to psychiatric and "related medical treatment", a phrase defined under the *Act*. Related medical treatment is limited to treatment required for the safe administration of psychiatric medication and for the treatment of adverse effects of psychiatric medication. If competent, the child has the same complete right to refuse or consent to treatment as an adult patient in the facility would

²¹³ [1971] 2 O.R. 103, 17 D.L.R. (3d) 139 (H.C.). For further discussion of this case, see Appendix V.

have. For other treatment, the common law rules apply. If incompetent, the usual list of substitute decision makers prescribed under section 1a takes effect.

The *Child and Family Services Act* provides that an individual having attained the age of twelve years may consent to counselling services, but if the individual is less than sixteen years of age, the service provider is to discuss at the earliest appropriate opportunity the desirability of involving the child's parents.²¹⁴ Children aged sixteen or over have the right to refuse or consent to "intrusive procedures", as prescribed in the regulations.²¹⁵ Beyond these provisions, the *Child and Family Services Act* is more important for what it does not say about consent to medical treatment than for what it does. When a child is found in need of protection, and when conditions are such that it is placed under the care of the Children's Aid Society or is made a Crown Ward, it has already been noted that the court has discretion as to whether the right to make treatment decisions about the child will also be transferred from the parent. The *Act* is clear, however, that even if this power is transferred to the society or the Crown, the power is only that which the parent possessed.²¹⁶ If the child is competent to make a treatment decision, the common law rules apply. The society or the Crown does not acquire the right to consent for mentally competent minors, and the child continues to have the right to make his or her own decision regarding the treatment.

A number of statutes provide authority for the assessment or medical examination of individuals including minors.²¹⁷ These statutes do not generally discuss consent in the context of these assessments. There is judicial authority, however, for the proposition that the common law of consent may continue to apply when an attempt is made to impose treatment for an adult under the *Criminal Code*, and that the subject is not obliged to co-operate with treatment. The same case holds that insofar as the federal legislation purports to require compliance with treatment even absent consent, it is in violation of the division of powers sections of the *Constitution Act*.²¹⁸ There is no obvious reason that similar arguments could not be made regarding children.

²¹⁴ See section 28.

²¹⁵ See s.125(4). For children under this age, the parent may consent to these procedures.

²¹⁶ See sections 58 and 59.

²¹⁷ See, for example, *Child and Family Services Act*, s.50; *Mental Health Act*, ss. 9, 10, 11, 14, 16, and elsewhere; *Young Offender's Act*.

²¹⁸ See *R. v. Shepherd*, (not yet reported, District Court of Ontario, 1989).

Regulation 865 under the *Public Hospitals Act* requires that, except in cases of urgency, surgical intervention may only be performed on a person under the age of sixteen years with the consent of the individual's parent or guardian. Also, where a hospital administrator requires a written consent for a treatment, the individual's parent or guardian must sign the consent if the individual is under sixteen years of age.

The regulation set the age until which parental consent would be required at eighteen years. It is not at all clear why that age was selected. In 1952, a parent's responsibilities toward his or her children under the *Children's Maintenance Act* ceased when the child reached the age of sixteen years. It is at best dubious based on the wording of that *Act* that the parent was civilly obliged to provide health care to the child, but it is clear that no civil duty attached beyond that age, absent parental undertaking to pay for treatment.²¹⁹ Consistent with this threshold age of sixteen, welfare became available to emancipated minors at that age later in the 1950s.²²⁰ It seems somewhat absurd to say that an individual would be outside the scope of parental responsibility, could move away from home and form his or her own household, but could not consent, for example, to a tonsillectomy.

It is difficult to know what to make of this regulation. It was passed originally in 1952.²²¹ It is tempting to associate its passage with the Supreme Court of Canada decision in *Vancouver General Hospital v. Fraser*.²²² In that case, the court held that a hospital could be legally responsible for the failure of some interns in its employ to read X-rays properly. As a result, an operation was not performed, and the injured person suffered severe damages. The imposition of liability upon the hospital was a marked departure from the existing common law of the period, which had held that hospitals were liable only for administrative tasks performed by its employees, not tasks related to the professional expertise of the employee.²²³ This case does not adequately account for the regulation, however.

²¹⁹ See *St. Catharines General Hospital v. Sviergula*, [1961] O.R. 164.

²²⁰ See O.Reg. 207/58, passed under the *General Welfare Act*, S.O. 1958, c.33.

²²¹ As regulation 729/52.

²²² [1952] S.C.R. 36.

²²³ This distinction flowed from the decision of the King's Bench division in England, in the case of *Hillyer v. St. Bartholomew's Hospital*, [1909] 2 K.B. 820.

The regulation at that time referred only to surgical intervention, and, therefore, would not address the *Fraser* case, where such intervention was not undertaken.

It is similarly tempting to argue that the consent of the parent was the equivalent of a legal retainer, thus guaranteeing payment for service by the consentor. This argument is particularly consistent with the court's desire to find some express or implied undertaking to pay the bill by the family of the patient, to have the law reflect what were perceived as the moral obligations of the family. The difficulty with taking this view of the regulation is that if the object were to ensure payment, the minor would not have had full contractual rights until the age of twenty-one. In any event, the impecunious minor over the age of sixteen was considered an indigent, and the municipality was required to pay for his or her health care as a result. Thus, the hospital would have been paid in the long run.

The subsequent amendments to the regulation do little to clarify it. In 1971, the age of majority was lowered to eighteen years, and parental responsibility under the *Children's Maintenance Act* was increased until the child had reached eighteen years of age. For three years, the system would appear to have been relatively consistent, but in 1974, the Public Hospitals regulation was amended, and the age of sixteen years was substituted for eighteen years.²²⁴

The identical regulation under the statutes of Prince Edward Island was considered in the *Eve* case. That case held that the regulation did not purport to establish the validity of the consents, but instead was intended to ensure written and signed consents in some circumstances. The court reasoned:

The enumerated consents and necessity are at law valid defences in certain circumstances to a suit for battery that might be brought as a result of an unauthorized operation. So, for the purposes of managing the workings of the hospital, the regulations require that these consents be signed. They do not purport to regulate the validity of the consents; this is otherwise governed by law. Indeed, I rather doubt that the *Act* empowers the making of regulations affecting the rights of the individual, particularly a basic right involving an individual's physical integrity.²²⁵

The difficulty with this is that it does not particularly reflect the wording of the regulation at issue. Further, if the child is competent, it is the child's consent which is relevant at common law. The parent's consent provides no defence to anything, as the common law does not give the parent the right to consent. The regulation

²²⁴ See O. Reg. 100/74, s.11.

²²⁵ (1986), 13 C.P.C. (2d) 6 at 22 (S.C.C.). For further discussion of this case, see Appendix II and Appendix IV.

on its face appears to do precisely what His Lordship states it probably cannot constitutionally do, that is, regulate the validity of consents. If that is the case, cognizance of the closing sentence quoted above must be taken, and the validity of the regulation is highly questionable.

It is perhaps best to view the regulation as an historical curiosity. It pre-dates the major legal developments of the 1960s, 1970s and 1980s regarding negligence, informed consent and battery. It is out of step with the common law, and statute law. The *Eve* decision has cast its very validity into doubt, creating uncertainty in the medical and legal communities. It would appear from *Eve* that it is either invalid or irrelevant. This confusion ought to be clarified by a proper statutory amendment.

The common law provisions regarding minors and the release of their clinical records is not clear. While the courts have generally held that a patient has a right to view his or her clinical record, the cases have not dealt with applications by minors. The minor's right to prevent other people such as parents from viewing his or her clinical record has similarly not been the subject of litigation.

Both the *Mental Health Act* and the *Child and Family Services Act* contain provisions regarding the release of the clinical record and access to health information and reports. The *Mental Health Act* provides competent patients with a *prima facie* right to view and copy their clinical record, subject to restrictions concerning material which might be harmful to the treatment or recovery of the patient while in the facility, or to the physical or emotional health of a third party. Competent minors are dealt with under the *Act* in the same fashion as adults, although the rebuttable presumption of incompetence regarding individuals under age sixteen applies in the context of clinical records. Minors who are party to review board hearings have the same rights as adults to copy any documents to be produced at the hearing, irrespective of competence. In addition, the lawyer of a child who is a party to a review board hearing may view the clinical record, and the *Act* specifically does not preclude the lawyer or agent to disclose the content of the records to the client, irrespective of the client's age or competence.^{22b}

The *Mental Health Act* gives a competent patient the right to have his or her clinical record disclosed to other individuals, and except in narrowly defined cases

^{22b} s.33d. Note that other law may preclude the disclosure of this information. Possibly significant in this regard are the Rules of Professional Conduct of the Law Society, which place some restrictions on what lawyers may disclose to their clients from medical reports.

involving treatment of the patient or research, to restrict the disclosure of the clinical record to other persons. If the patient is incapable of consent to treatment, however, the *Act* makes a specific provision that the substitute decision maker may view the clinical record.²²⁷ The substitute decision maker for a child under sixteen will be the parents or guardian of the child. The *Act* does not appear to contemplate a situation where a child does not want his or her parent/substitute to see the clinical record, and the two provisions cited therefore come into conflict. The best legal view is that because of the phrasing of the *Act*, the right of a substitute to see the file will take precedence over the right of the patient to privacy. Note that this situation will arise only in the statistically unusual case where the patient is capable regarding record release, but incapable regarding treatment.

Under the *Child and Family Services Act*, age thresholds for access to information are set without other reference to capacity. At age twelve, the child acquires a *prima facie* right to a copy of the medical report which forms the base of a child protection proceeding.²²⁸ This right flows from the child's party status at these proceedings. An individual over the age of twelve also has a right to view his or her own clinical record.²²⁹ The *Child and Family Services Act* addresses the right of the child to privacy directly, by providing that the treating facility may disclose the record of the child to third parties upon the consent of the child's parent until the child has reached sixteen years of age, when the child is given this consent power.²³⁰ This section does not apply to counselling records where, as has been noted, the child may consent to treatment without parental involvement at age twelve.

C. CHILDREN'S AUTONOMY AND THE ROLE OF THE FAMILY

The rights, duties and authority of parents and children thus form a complicated web regarding the issues of concern to the Enquiry. The Enquiry is to confront the interface between the principles of family law and health law. The family is recognized as a basic social unit, and the unit in which children are best

²²⁷ Section 29a(16).

²²⁸ s.50(5). The court may also order disclosure to an individual under the age of twelve, when it considers it advisable to do so: s.50(4). At this age, the child also receives an unqualified right to view the court file in any criminal case against him or her: see *Young Offenders Act*, R.S.C. 1985, c. Y-1, s.44.1.

²²⁹ s.167.

²³⁰ s.165.

raised. Some of the social importance placed on family relationships is reflected in the law. The recent family law theory stresses the need to perpetuate and support these family relationships, and to ensure a stable, continuous and loving environment for the development of children.²³¹ The tension in health law has been very different around the issue of competency with paternalism and the protection of people of limited abilities on the one hand, and civil rights and personal autonomy of the capable patient on the other. Regarding children, therefore, the issue is not merely finding a balance between civil rights and state paternalism. The Enquiry is also to be concerned with the dangers of intruding into the family relationship, and the need if not to foster, at least not to impede relationships within the family which are productive, happy and meaningful.

There is a primary set of assumptions that must be addressed. There is firstly a tacit assumption that there is a family, available to be involved in decision making for the child. The law allows emancipation of minors from parental control at a relatively young age. The *Child and Family Services Act* provides authority to return children to their parents only if the children are both under the age of sixteen and at risk.²³² In the case of the emancipated minor, the argument for family involvement becomes much less compelling. Similarly, children who are institutionalized for long periods may be distanced from their parents. The loss of the day-to-day contact with their children may limit the persuasiveness of the argument for parental authority.

It is further generally assumed in law that the parents are the appropriate guardian of the child's best interests in the context of personal guardianship. This belief is based on cultural assumptions regarding the nuclear family as it has developed in the nineteenth and twentieth century Anglo-Saxon tradition. In other cultures, it is not uncommon for the extended family to take a much more active role in the development and guidance of the children. We have been fortunate on our advisory panel to have an Native social worker. In that culture, the band is a more central social unit than the biological family. This is reflected in the *Child*

²³¹ The classic text expounding the need for the perpetuation of such bonds is J. Goldstein, A. Freud and A. Solnit *Beyond the Best Interests of the Child* (New York: Free Press, 1973). These authors argue that the essential role of family law is to protect the best interests of the child, and this is to be achieved by centring attention on the psychological ties and psychological needs of the child. The aim is to create a "psychological family", which may or may not correspond to the biological family. For example, Goldstein, A. Freud and A. Solnit, argue that interim placements in foster care should be as short as possible, with adoption, if it is to occur at all, to be finalized as soon as possible so that the child may develop firm and consistent psychological ties. This emphasis on speed may work to the disadvantage of the biological family.

²³² Section 40(c).

and *Family Services Act*, where the band receives many of the notices in child protection and adoption proceedings regarding Native children which would normally be received by the parents of the child. While the Anglo-Saxon norm has tended to be reflected in family law, the Enquiry must remain aware of the multi-cultural nature of Canadian society, and not too readily assume the existence of a "traditional" nuclear family.

If these assumptions are made, it remains to consider the arguments that parents are the appropriate persons to make treatment decisions for their children. Landau, an advocate for children's involvement in treatment decisions, provides the following six arguments against her position, and these six arguments provide a useful framework for considering some of the strengths and weaknesses of parental involvement.²³³

1. Parents are the natural advocates for their children and are motivated primarily by considerations of their children's best interests.
2. Children and parents have such similar interests that independent representation of children is unnecessary.

These first two arguments may be dealt with together, as they contain the same assumptions. For all their devotion and concern, parents are not their children. Parents have a strong and independent emotional investment in their children, which may or may not correspond with the child's best interest or wishes. A parent may be prepared, for example, to consent more readily than is appropriate to psychiatric treatment or sedation for a child, out of a concern to restore family peace and functionality thereby reducing the stress on the parent. This decision is little motivated by a concern for the possible adverse affects of the drugs or what are in law understood as the child's best interests. The personal involvement and conflict felt by a parent is obvious in the facts of the *Strunk* case,²³⁴ where a consent was sought for an organ transplant from a child, to his brother. The child who wishes birth control provides another obvious example. The medical issue of the desirability of the medical treatment is inextricably bound with the non-medical issue of the desirability that the child be sexually active.

²³³ B. Landau "The Rights of Minors". In B. Landau, (ed.), *Children's Rights in the Practice of Family Law* (Toronto: Carswell, 1986) at 93f.

²³⁴ 445 S.W. 2d 145 (Ky., 1969).

While these are particularly clear examples, there is no reason to believe that parents are beyond other conflicts.

The situations in which capacity will be an issue are also to be considered. If the parents and the child agree, there is likely to be no issue as to capacity, because notwithstanding who has the authority to consent, the decision will be the same. It is when the parents and the child disagree that the decision must be made to accept one decision and reject the other. It may be that the disagreement is an isolated occurrence in an otherwise harmonious family. The adolescent seeking birth control, for example, may otherwise have a very good relationship with her parents. Alternatively, it may be that the disagreement concerning treatment is but one manifestation of other problems within the family. If the failure to agree is a symptom of a generally dysfunctional family, the arguments for parental involvement in decisions regarding an otherwise capable child lose much of their persuasiveness. Emotions may be running high in the family on a wide variety of issues, and the treatment issue may be but one small part. It is clear in this situation that the parent and child will perceive their interests as different; it is not clear who will be arguing in whose best interest. It may be that in some situations an appropriate program of family counselling could alleviate at least some of the rifts in the family. Treatment decisions cannot necessarily wait for such healing, however. In this situation, the determination as to who will make the decision may become a way of one side of the family dispute manifesting its power over the other.

3. The goal of ensuring family privacy and autonomy takes priority over introducing the state as an arbitrator of family disagreements.

This argument pre-supposes state involvement, juxtaposed with the private affairs of the family. This is a false dichotomy. The issue is not whether the decisions regarding the child's health care will be made by the state or the family, the public or the private; the issue is which private decision maker will make the decisions: the parent or the child. Failing to intervene in "family disagreements" and leaving the disagreement without guidelines as to who is to have the final decision making function leaves no rule for the resolution of the disagreement. The problem will remain: whose decision is to be acted upon? Absent rules, the effective decision is likely to be made by the individual with the most power, presumably the parent in most cases. This may be the proper result, but it is not the proper result simply because the parent is more powerful.

An issue has been raised that introducing more comprehensive capacity assessment may intrude into the privacy of the family relationship through the provision of due process safeguards. This is certainly an issue which warrants consideration. An adversarial hearing may well be disruptive of a friendly family atmosphere. This is an implementation problem, however. It is not *prima facie* obvious that simple rights advice, if given sensitively, will necessarily create unnecessary problems in the family structure. And in the event that the child is unhappy with the parents making the decisions regarding his or her treatment and wishes to challenge their authority to do so, in some cases the child might have good reason to do so.

4. Minors lack the capacity to make reasonable judgments as to their needs, so it is desirable to let the parents, who have more mature judgment, speak for them.

At its simplest level, this begs the question. Certainly, minors who are not capable to make decisions ought not be making those decisions. The question becomes at what stage the minor has acquired sufficient judgment that his or her decisions ought to be respected.

At a more complex level, the point is less easy to dismiss. If one accepts the notion that the issues concerning competence not only include the provision of basic civil rights, but are also intended to generate good decisions, the issue is not merely whether the minor makes adequate decisions, but also whether the parent will make sufficiently better decisions to warrant maintaining the decision making authority until relatively late in the child's development.

The point raised also suggests two separate criteria for capacity. Firstly, there is an issue of psychological development. Secondly, the point refers to an issue of maturity, or life experience. The parent is bound to have lived a broader and fuller life than the child. Is this to be considered in assessing the child's competence, or, is the test of capacity to be limited to more strictly psychological factors? The parent may entirely lack direct experience with the actual medical condition faced by the child. Does this counteract in any way the advantage possessed by parents, flowing from their broader experience?

5. The provision of health care is a desirable service aimed at preventing future, more serious social problems and at improving the present quality of life for the child and family. Therefore, it is better to err on the side of ensuring that treatment is obtained rather than encouraging reluctant

patients to withdraw from its potential benefits. This is consistent with the state's interest in the general welfare of its citizens.

This point firstly assumes that treatment is *ex hypothesi* good, and therefore that the purpose of the system is to get a consent to treatment if possible. That is not the legal approach. We have seen that treatment is to be ordered by a substitute if and only if it is in the "best interests" of the patient, as that phrase is narrowly defined in law. In assessing those interests, rightly or wrongly, the quality of life of the family, for example, is not a factor which warrants major consideration.

The point also assumes that parents will consent to treatment more frequently than children. As will be discussed below, this assumption is not obviously warranted for all ages of childhood.

6. Mental health professionals are in the best position to offer the necessary protection, namely, that people are not admitted²³⁵ without proper justification. This matter is outside the expertise of the courts. In addition, it is undesirable to put a child through the emotional trauma of an adversarial court hearing to determine his or her treatment needs.

This argument applies equally to adults, and is frequently made, particularly regarding adults of marginal competence. The same arguments used against this argument in an adult context apply also with children. The physician or other health professional is in a conflict situation. The prescription of treatment is likely to imply a belief that the treatment will benefit the patient, and therefore that the patient ought to consent to the treatment. The aim of the physician is likely to be obtaining a consent, rather than to get a considered decision reflecting the wishes of the patient.

Furthermore, the decision to consent to or refuse treatment is not a strictly medical decision. It may have a wide variety of other components. It may be true, assuming a court review process were selected, that the court does not have particular expertise in all these areas, although the fact that courts have been assessing capacity in other contexts for centuries must cast some doubt on this claim. Equally important, however, is that neither is it the particular expertise of

²³⁵ Landau's article concerns both treatment and admission to treatment facilities. The point she refers to here remains a serious one, however: there are professional standards which require appropriate reasons for treatment recommendations by physicians.

the physician or other health professional. This has been recognized by the very introduction of the doctrine of informed consent.

Insofar as state intervention is required to determine capacity, it does not follow that the job will fall to the court. At least at first instance, it might be made by a physician. Alternatively or upon review, it might be made by a review board. Such a board could be constructed to have the expertise which is of concern.

Finally, the assertion does not address the trauma of not having a review. Is it not possible that treatment may also be traumatic when administered to a capable minor without his or her consent? It is at least arguable that a minor who has reached a certain age will suffer psychological setbacks from the sense of disempowerment at not being able to control his or her own body. The psychological data on this point, such as it is, will be discussed below.

In considering the appropriate involvement for the family, some concern must be given to whose interests are to be protected. The law, as we have seen, is clear that it is the "best interests" of the child, as that phrase is narrowly defined, which governs, to the exclusion of other interests. Family law, too, has increasingly in recent years centred its attention on the needs of the child, to the exclusion of the needs of the parents. It is too glib to dismiss broader perspectives as considering the child as mere property of the parents.²³⁶ A family involves a set of relations. The social issue is whether in law, the treatment of a minor is to be perceived solely from the perspective of the minor, or from the broader perspective of the family as a whole.²³⁷

Even if the recent trends in family law are followed, and the sole interests to be considered are those of the child, it becomes a question as to how the child's interests are to be understood. The arguments for setting a relatively high age of consent for children are based on the assumption that the parent's decision is likely to be more capable and more mature than that of the child; it will be a qualitatively better decision. This theory associates the child's interests solely with the outcome of the decision. It does not consider that the child may have an interest not merely in the substance of the decision, but also in the process which

²³⁶ The juxtaposition between child as property and the best interests of the child is made, for example, in L. Weithorn "Involving Children in Decisions". In G. Melton, G. Koocher and M. Saks, (eds.), *Children's Competence to Consent* (New York: Plenum Press, 1983) at 240.

²³⁷ An argument for approaching decision making in the context of the family as a whole is contained in F. Schoeman "Childhood Competence and Autonomy". (1983) 12 *Journal of Legal Studies* 267.

is selected. This omission is challenged by persons favouring child involvement in decision making. Weithorn, for example, argues that involving children in decision making from an early age promotes the positive psychological functioning and psychological well-being.²³⁸ Others have argued, however, that too much independence and control by the child at too young an age may merely bewilder the child, thus having a detrimental effect on the child.²³⁹

There is some evidence that a significant number of marginally competent children want their parents involved in the decision making. In a study by Lewis conducted in 1976,²⁴⁰ 213 school children between the ages of six to nine were invited to participate in a trial of a flu vaccine. Those participating were told in advance that if they consented to the trial, their parents would also be required to consent, prior to the research being conducted, but that if the participants refused, their refusal would stand and no parental involvement would be sought. Forty-six per cent refused involvement in the trial, thus making a decision without parental involvement. These were disproportionately the younger children. Twenty-one per cent of the children indicated that they wanted to participate. These children were aware that their parents would also have to consent, so that

²³⁸ L. Weithorn "Children's Capacities for Participation in Treatment Decision-Making". In D.H. Schetky and E.P. Benedek, (eds.), *Emerging Issues in Child Psychiatry and Law* (New York: Brunner/Mazel, 1985) at 22. The thrust of this argument is contained at page 27. Weithorn contemplates a range of involvement possibilities for children, including autonomous decision making in the event that the child is capable, consultation with the child about treatment options with the child's preferences taken into account, and lesser decisions within the framework of the regimen selected by the parent, such as deciding the balance between increased medication and increased adverse affects of the medication.

²³⁹ See, for example, the following passage from P. Wald "Legal Policies affecting Children: A Lawyer's Request for Aid". (1976) 47 *Child Development* 1, quoted by G. Melton "Decision Making by Children". In G. Melton, G. Koocher and M. Saks, (eds.), *Children's Competence to Consent* (New York: Plenum Press, 1983) at 22:

I have often wondered when I was representing a child in a delinquency or neglect proceeding, what it meant for me to go up to a 9- or 10-year-old and say, "I'm your lawyer. Here I am; tell me what to do. What do you want me to do in representing you?" ... What are the long-term consequences for a child of being told you have a lawyer, you have rights, and we are going to defend you in court? Does this give children a sense of self-esteem, of controlling their own fate, a sense of powerfulness? Or does it leave them bewildered? How are children different who have gone through such proceedings?

²⁴⁰ C. Lewis, M. Lewis and M. Ifekwunigwe "Informed Consent by Children and Participation in an Influenza Vaccine Trial". (1978) 68 *American Journal of Public Health* 1079. The children involved were already involved in a program whereby they were given increased decision making power regarding the school health care system, and were thus more accustomed than average children to making their own health care decisions. It may be that this sample would be more likely than average to make the decision in the study themselves, without parental involvement. If this were the case, the number of children wishing parental involvement would be higher in the general population than the study would indicate.

it is ambiguous whether they wanted parental involvement in this decision. The remaining thirty-three per cent chose the third option on the consent form, that they wished their parents involved in the decision, and were not expressing a preference regarding participation. The study does not indicate whether there was an age differentiation in the expression of this preference. While this group of children are certainly a significant enough number to consider, it is also to be recalled that nothing in a system of capacity determination need preclude consultation with the parent for children who wish to do so; the issue is whether parental involvement is to be required.

D. THE DEVELOPMENT OF CHILDREN: WHAT THE RESEARCH SHOWS

As has been discussed throughout this report, competence is a complex construct, involving a wide variety of variables. Psychological factors, emotional factors, maturity, affective disorders, the nature and complexity of the decision to be made, the ramifications of the decision to be made, social issues, and the availability and calibre of substitute decision makers may all be argued to affect the decision as to whether or not an individual is capable. No empirical test can evaluate all of these factors. Some of these factors may not be amenable to an empirical test. How, for example, does one test maturity? As a result, while consideration of empirical data is certainly relevant to the considerations of the enquiry, it cannot be seen as determinative. In addition, much of the research cited by individuals, concerned with the capacities of children, actually concerns the development of children outside a health context. Its relevance is further limited in this way.

The research on psychological abilities of children would suggest that by about the age of fourteen, a child's analysis of proposed treatment will be at the same level of reasoning as that of an adult. This is reflected in the work of Weithorn and Grisso and Vierling, who found that on a scale of capacity ranging from the mere ability to manifest a choice to the ability to appreciate the nature of treatment, fourteen-year-olds were capable of the highest standard of mental

reasoning.²⁴¹ Piaget set the age at which a child had the necessary conceptual skills to consent to treatment marginally later, at fifteen years of age.²⁴²

Research cited by Grodin and Alpert²⁴³ highlights the different types of reasoning employed by children at various stages in their development. Children less than seven years of age employ reasoning structures which may not be entirely rational. They tend to utilize "magical thinking", for example, which may lead them to believe, for example, that death is reversible, or that an amputated limb will regrow. The authors suggest that this type of thinking will preclude the possibility of informed consent. Children from age seven to thirteen, they suggest, will see the world in concrete terms and not employ the magical thinking of the younger child. They suggest that the child of this age will have difficulty anticipating the future, however, thus limiting the ability to provide informed consent. It is unclear whether they understand this limitation as flowing from psychological development or lack of experience of the world. Finally, children over the age of thirteen years, they argue, are as capable as adults of understanding their medical problems. Reasoning power alone, in this analysis, would not preclude the child from providing informed consent.²⁴⁴

The research is fairly consistent that if reasoning ability alone is the guide, children over the age of fourteen years are likely to be as capable as average

²⁴¹ T. Grisso and L. Vierling "Minors' Consent to Treatment". (1978) 9 *Professional Psychology* 412; L. Weithorn "Developmental Factors and Competence to make Informed Treatment Decisions". (1982) 5 *Child and Youth Services* 85; L. Weithorn and S. Campbell "The Competency of Children and Adolescents to make Informed Treatment Decisions". (1982) 53 *Child Development* 1589; all cited in L. Weithorn "Children's Capacities for Treatment and Decision-Making". In D.H. Schetky and E.P. Benedek, (eds.), *Emerging Issues in Child Psychiatry and the Law* (New York: Brunner/Mazel, 1985) 22 at 29.

²⁴² Cited in B. Landau "The Rights of Minors". In B. Landau, (ed.), *Children's Rights in the Practice of Family Law* (Toronto: Carswell, 1986) at 100. For a detailed discussion of the development of cognitive and emotional skills in children see Committee on Child Psychiatry, Group for the Advancement of Psychiatry, *How Old is Old Enough? The Ages of Rights and Responsibilities* (New York: Brunner/Mazel, 1989) at 19-36. See also J. Piaget "The Affective Unconscious and the Cognitive Unconscious". (1973) 21 *Journal of the American Psychiatric Association* 249 and also on the issue of moral development L. Kohlberg "Development of Moral Character and Moral Ideology". In M. Hoffman and L. Hoffman, (eds.), *Review of Child Development Research* (New York: Russell Sage, 1964) at 383-432. See also R. Siegler *Children's Thinking* (Englewood Cliffs: Prentice-Hall, 1986) at 21-61.

²⁴³ M. Grodin and J. Alpert "Informed Consent and Pediatric Care". In G. Melton, G. Koocher and M. Saks, (eds.), *Children's Competence to Consent* (New York: Plenum Press, 1983) at 96. Grodin and Alpert cite a number of scholars for their conclusions, including Piaget, Bibace and Walsh, Koocher, and Erikson.

²⁴⁴ It is open to question how useful the authors' comments regarding capacity to consent are, given that no indication is provided of what treatment the child is being asked to consent to. Are we to understand that seven to thirteen-year-olds can consent to no treatment?

adults.²⁴⁵ Reflecting the experience of parents with adolescent children, some research also indicates that adolescence is when the child is coming to terms with individuation and separation, resulting in conflicts with authority figures and susceptibility to peer pressure. It has been speculated that this may interfere with the ability of the adolescent to decide according to his or her best interests.²⁴⁶ This raises the issue whether capacity is merely a function of reasoning capability, or whether other psychological factors ought to be considered.

It is difficult to make generalizations regarding children between the ages of roughly eleven or twelve to fourteen. A number of authors recognize that an adult-like level of cognitive ability may be reached by the child by the age of eleven or twelve.²⁴⁷ A transitional period would appear to take place at roughly this time. This is reflected in the case by case approach implied in the Ontario *Mental Health Act* for persons commencing at age twelve.

The *Young Offenders Act* recognizes that by age twelve, the child has decisional capacity, as reflected in s.22(1). This section provides that:

No order may be made ... unless the youth court has secured the consent of the young person, the parents of the young person and the hospital or other place where the young person is to be detained for treatment.

The *Young Offenders Act* gives to children the vitally important decision of determining whether or not a treatment order can be made. The giving of consent is very rare, thus rendering the section effectively useless. This result seems inevitable because "many young persons who require counselling are unable to provide consent because of the very nature of their problems."²⁴⁸ On the one hand, it seems problematic that a child who is depressed, disturbed, angry, etc. has the unmitigated right to refuse to give consent. On the other hand, consent is arguably a necessity, in that absent the child's consent, he or she will lack the motivation to

²⁴⁵ See Committee on Child Psychiatry, Group for the Advancement of Psychiatry, *How Old is Old Enough? The Ages of Rights and Responsibilities* (New York: Brunner/Mazel, 1989) at 70-72 for a discussion of developmental level versus chronological age as the determinant of children's capacity to make treatment decisions.

²⁴⁶ See M. Grodin and J. Alpert, *supra*, at 96.

²⁴⁷ See the authors cited by L. Weithorn in G. Melton, G. Koocher and M. Saks, (eds.), *Children's Competence to Consent* (New York: Plenum Press, 1983) at page 245. See also T. Grisso and L. Vierling "Minors' Consent to Treatment: A Developmental Perspective". (1978) 9 *Professional Psychology* 412.

²⁴⁸ J. Hudson, J.P. Hornick and B.A. Burrows *Justice and the Young Offender in Canada* (Toronto: Wall & Thompson, 1988).

engage in an effective treatment programme, resulting in a waste of money and effort. A further concern is that the discretion of the court is ousted by virtue of the child's blanket power to refuse consent, a power he or she is not afforded with regard to other dispositions. It is clear that some middle ground must be reached, although a fuller discussion with regard to same is outside the ambit of this report.

Whereas the *Young Offenders Act* uses age twelve as the point in time where children have decisional capacity, the Canadian *Criminal Code* uses age fourteen to distinguish between children and adults. Sections 150 to 153 of the Code deal with sexual offenses committed toward children under age fourteen. Any individual below this age is afforded a unique status under this statute, and is to be dealt with differently; firstly, the offender will be recognized as having committed a sexual crime upon a "child", and secondly, the child receives the benefit of certain evidentiary innovations, such as videotape evidence, or testifying behind a screen. At age fourteen, the child is foisted into the adult world and loses his other unique status.

The recommendation of the Enquiry is to use the age of fourteen as the presumptive beginning of adulthood. While we do recognize that children have some degree of decisional capacity by age twelve, it is more sharply formulated by age fourteen.

The level of capacity of persons below the age of about twelve cannot simply be ignored. The Lewis study cited above involved children aged six to nine. In the discussion sessions leading up to the decision whether to consent to the flu vaccine trial, the children asked similar questions to those which would be asked by adults: what the probability was of a flu epidemic that year; what the adverse effects of the vaccine would be; and what the testing procedure would involve. In an adult, these questions would be considered evidence of capacity. Another study compared the understanding of nine year olds to that of eighteen and twenty-one year olds. All participants were given the same treatment dilemmas and information to be considered in solving the dilemmas. The adults understood eighty-nine per cent of the information; the nine-year-olds understood sixty-nine per cent. The study demonstrated that the nine-year-olds failed to take account of the diversity of risks and benefits of the treatments proposed, but instead focused on a few central and salient points, typically the alleviation of the symptoms present.²⁴⁹ Thus, the

²⁴⁹ L. Weithorn "Developmental Factors and Competence to Make Informed Treatment Decisions". (1982) 5 Child and Youth Services 85.

children understood less, but nonetheless understood a considerable amount, and perhaps the most significant information given.

Insofar as the choices made by minors can be considered relevant in assessing their capacity, the research is not entirely determinative. A study by Lewis of a school health system which gave the students aged five to twelve years a great degree of control in deciding to use it, demonstrated that the children's use of the health facility was roughly what would be expected of adults. The original research was conducted in a relatively wealthy school, but was repeated in a poorer area.²⁵⁰ In another study comparing nine-year-olds and adults, the children reached the same conclusion as did the adults in three out of four hypothetical treatment dilemmas.²⁵¹

In assessing the above information, it is necessary to take into account what the child is considered to be consenting to. Is treatment to be understood in terms of a significant surgical intervention, or a cursory physical examination of the child? Is a child capable of consent to the latter earlier than to the former?

The research indicates that children attain their adult reasoning capacities somewhere between eleven or twelve and fourteen. This means, however, that they are reasoning as an average adult would reason. An adult may be functioning at a significantly lower level than average, and yet still be capable of making treatment decisions. If the level adopted for adults, for example, is the ability to locate themselves in space and time, and have a rudimentary understanding of their illnesses, many six or seven year-olds would become capable as they too have this understanding. If concern about possible adverse effects and the consequences of not becoming involved in the treatment program are to be considered as firm markers of capacity, a significant number of the students in Lewis' study would be capable.

As was suggested above, the issue regarding the capacity of minors does not merely concern the substance of the decision to be made; it also concerns the process of decision making. It therefore becomes relevant to determine at what point the child wishes to have, or is at least capable of understanding, the power

²⁵⁰ C. Lewis "Decision Making Related to Health: When Could/Should Children Act Responsibly". In G. Melton, G. Koocher and M. Saks, (eds.), *Children's Competence to Consent* (New York: Plenum Press, 1983) 75 at 79.

²⁵¹ L. Weithorn and S. Campbell "The Competency of Children and Adolescents to Make Informed Treatment Decisions". (1982) 53 *Child Development* 1589.

to make a decision concerning his or her treatment. A certain amount of work has been conducted on juvenile understanding of rights in a criminal law framework,²⁵² but query how applicable this research is to an understanding, that one is entitled to make a decision about the treatment or examination of one's body in a medical context.

E. DECISIONAL CAPACITY AND FAMILY CONCERNS

From the foregoing, it would appear that the assessment of capacity must strike a balance between the child's developing abilities and need for autonomy, the parents' need to care for their child, and the parents' greater maturity and experience. A child's capacities increase as the child grows older, from little ability until the age of six, to reasoning abilities similar to adults by about age fourteen.

The system arrived at must also take account of the wide varieties of treatment a child may seek or need. There is an intuitive appeal to the proposition that because of the consequences involved, a child may be capable, for example, to decide as to the desirability of minor cosmetic surgery, but not surgery upon which the child's life may depend. There is an irony to this, as the law would place particularly stringent restrictions on the consent to cosmetic surgery, at least in terms of the information which must be provided.²⁵³ There is the temptation to require a lower level of capacity for matters where the child is likely to value his or her privacy, such as counselling or treatments for venereal disease, out of a concern that the child will not seek treatment if there is a danger that his or her parents may be informed.

There is a tendency to think of capacity only in terms of relatively major treatments. Under the common law test, by comparison, how old does one need to be to consent to a throat swab? This appears to be a trivial example, but minor procedures can give mixed messages. An obvious example is genital examinations by general practitioners. More and more frequently, parents are "street-proofing" their children from a very young age, teaching them that they need not consent to adults touching their private parts. Does allowing the doctor to touch the patient in these areas without consent give the child mixed messages? At what age, therefore, should a doctor be asking for a child's consent to such an examination?

²⁵² See T. Grisso *Juveniles' Waiver of Rights: Legal and Psychological Competence* (New York: Plenum, 1981), a study of minors' understanding of their Miranda rights.

²⁵³ See *Petty v. MacKay* (1979), 10 C.C.L.T. 85, 14 B.C.L.R. 382, for example.

A distinction is to be drawn between determining a child's capacity to consent, and involving the child or parent in the treatment program consented to by the other. The latter may be done in a number of ways. Opinions may be sought, discussion between the parties may be encouraged, and treatments may be explained. If a parent makes the large decisions concerning treatment, such as what treatment will be performed, it does not prevent the child from making smaller determinations, such as the days treatment will be performed or the appropriate balance between dosage of the drug and adverse effects of the drug. It appears now beyond reasonable doubt that it is good clinical practice for the physician to recognize the human fears, concerns and other feelings of all individuals involved in the treatment program, and to accommodate those within the bounds of the law and ethics.

There are limits to such involvement, of course. When discussing a procedure with the individual who does not have decision making authority, for example, the physician may be left in a difficult situation if the individual asks that the procedure not go forward. The individual could, in such a situation, feel betrayed by the physician in the event that the procedure is performed.²⁵⁴

Under existing law, however, a determination of capacity as regards a specific treatment does not merely result in the involvement of the child in the development of the treatment program. It gives the child complete decision making authority regarding the treatment. The decision that the child is incapable deprives the child of all decision making authority in the treatment. A line is created in which flexibility is not available. Both of these extremes have advantages and disadvantages.

If the parents have the power to consent, at least in theory, a considered and mature judgment will result. This is clearly the desirable option for very young children. For some types of treatment, it may also be the preferred option for even relatively mature children. As the child matures, however, problems with this

²⁵⁴ This point is made by M. Grodin and J. Alpert, *supra*, at 98:

One need not ask the young child's permission to carry out a necessary painful procedure such as blood drawing. If the physician does make such inquiry, the child will undoubtedly refuse what is deemed a necessary procedure. By proceeding further despite the refusal, the physician has reduced the likelihood of retaining a trusting relationship with the child. Instead, a warm and sensitive explanation of that procedure and its necessity ("I need to do a blood test. It will hurt, but ...") may go a long way in terms of cooperation and allaying fear and anxiety.

option arise. It does not address the need of the child to assume independence, nor the child's need for privacy. The decision making power of the parent is also limited, as we have seen, to what in law is considered to be the best interests of the child.

Giving the child the power to consent is an unnerving option for some types of treatment, particularly if a relatively low threshold of capacity is adopted. Whether based on rational beliefs in the child's maturity or irrational paternalistic assumptions, it strikes one as wrongheaded to give a young child the power of consenting to or refusing life-sustaining treatment. On the other hand, involvement of minors from a relatively young age in lesser treatment decisions may provide the opportunity to develop decision making skills in the treatment context. It has further been argued that giving a child a major role in the determination of treatment increases compliance with the treatment plan, particularly if the plan is a long one.

In other areas of law, children are not given control in their own right over the course of a decision, but their consent is required prior to the decision becoming effective. For adoption applications, for example, the consent of the child is required if the child is aged seven or more, and there are due process safeguards in place to ensure that the child's consent in fact reflects the child's wishes.²⁵⁵ Dual consent has not been required in Ontario for provision of health care, although it is the position of the American Association of Pediatricians that consent from both the parent and the child be required for children over the age of thirteen years.²⁵⁶

This dual consent system would appear to have many of the flaws of the previous two options, but not their strengths. As the parent would have consent rights, the privacy interests of the capable child would not be respected. The fact that the child could veto treatment would create the same uncertainties about life-sustaining treatment that exist where the child has sole authority for treatment. The strength of the dual consent provision lies in the fact that treatment will not be performed without the mature consent of the adult, and the autonomy rights of the child are recognized and respected.

²⁵⁵ See *Child and Family Services Act*, s.131.

²⁵⁶ Cited in M. Grodin and J. Alpert, *supra*, at 95. The Association also recommends that the consent of children over seven years of age be obtained for any research procedures, and that the refusal of the child to consent, or the wishes of the child to discontinue the process once commenced, must be respected.

Theoretically, it would also be possible to have a system where treatment could be performed on the consent of either the parent or the child. This is a theoretical possibility which would appear not to be used anywhere in law. It is not a particularly desirable option. Once again, the privacy rights of the child are not respected, nor are the autonomy rights of the child respected, nor is there a guarantee that the decision of the parent will be mature or appropriate under the circumstances.

F. DECISIONAL CAPACITY IN CHILDREN AND ADOLESCENTS - SUMMARY

In light of the above findings on the development of capacity in children, we propose that those under the age of majority be treated in the following manner:

- 1) That young persons age 14 or above be treated as adults with respect to their decisional prerogatives, and accordingly be assessed as adults where their capacity is in question.
- 2) In most cases both the young person and parent(s) or guardian will agree on a decision and it will not be necessary to assess the young person's capacity.
- 3) In situations in which a young person wishes to make a decision without the involvement of a parent(s) or guardian, a formal assessment must be made to determine whether the young person is capable. If found capable the young person's decision must be respected, if determined to be incapable this decision may not be made without the authorization of the young person's parent(s) or guardian.
- 4) Similarly in those situations when the young person and parent(s) or guardian disagree, a formal assessment must be made to determine whether the young person is capable. If found capable the young person's decision must be respected. If determined to be incapable the choice of the young person's parent or guardian (subject to applicable legal constraints) will prevail.

XII. SENIOR CITIZENS AND MENTAL CAPACITY

A. DEMOGRAPHICS AND LEGAL OVERVIEW

Like minors, the members of the geriatric population are frequently presumed to be incompetent and are often denied their choice in a variety of circumstances. Some of the most important choices are those involving life style (in particular place of abode), treatment, and financial matters. A number of social trends make the problems of decisional capacity in the geriatric population of increasing importance. These include the disruption of the nuclear family, increased mobility of all segments of society, increased awareness of individual rights and the changing demographic profile. The population over the age of sixty-five years has grown considerably since the turn of the century. In 1901, there were roughly 250,000 persons resident in Canada in this age range; by 1981, there were roughly 2.4 million. This number is expected to more than double by 2021.²⁵⁷ Proportionally, persons over the age of sixty-five represented nineteen per cent of the Canadian population in 1981; by 2001, that figure is expected to reach 24 per cent of the population.²⁵⁸

The growth in the Canadian population over the age of eighty years has been even more dramatic. In 1901, this group numbered less than 40,000; by 1981, they numbered 451,000, a number which is expected to reach over one million by 2021.²⁵⁹

It is generally assumed that the members of the geriatric population are more likely than average to suffer from various forms of mental deficits, an assumption which will be examined further below. Insofar as this assumption is correct, the issues surrounding decisional capacity and the geriatric population represents a very significant issue for the Enquiry. Far from being an interesting tangent to the issues surrounding the non-geriatric mentally disordered, the Enquiry has been aware that issues surrounding decisional capacity and the geriatric population parallel the more general psychiatric issues in their scale.

²⁵⁷ Health and Welfare Canada *Fact Book on Aging in Canada* (Ottawa: Minister of Supply and Services, 1983) at 14. By comparison, the general population grew by about four and one half times between 1901 and 1981, from 5.4 million to 24.3 million. As of 1981, there were 868,000 persons over the age of 65 resident in Ontario: *ibid* at 25.

²⁵⁸ *Ibid* at 18.

²⁵⁹ *Ibid*. at 14. In 1981, 171,000 persons over the age of 80 were resident in Ontario.

The law of competency does not provide special provisions for senior citizens, and thus the common law applies, unless modified by the statutes already discussed in these Appendices. Absent the appointment of a guardian of the person or estate under the *Mental Incompetency Act*, seniors are presumed competent to make wills and contracts, make medical decisions, and appoint substitute decision makers, and have the same rights to view their clinical records as anyone else in the population.

Advanced age in and of itself does nothing to change this presumption. However, commencing at the turn of the eighteenth-nineteenth centuries, incompetence flowing from advancing years became a justification for the invocation of the Royal Prerogative. This is reflected in section 39(1) of the *Mental Incompetency Act*, which allows the appointment of a committee for an individual who is "through mental infirmity, arising from disease, age or other cause, ... incapable of managing his affairs".²⁶⁰ Thus, if a geriatric individual becomes so senile as to be incompetent, for example, the *Act* does not require further diagnosis or justification for the appointment of a committee of the estate.²⁶¹

The procedures established under the *Mental Health Act* apply to the facilities listed in the schedules to that *Act*. These are primarily the ten provincial psychiatric hospitals, a large number of general hospitals which offer psychiatric services, and a few mental health clinics. Psychogeriatric wards contained in provincial psychiatric hospitals and general hospitals are therefore included in the

²⁶⁰ *Mental Incompetency Act*, R.S.O. 1980, c.264, s.39(1).

²⁶¹ Section 39(1) refers only to those provisions of the *Mental Incompetency Act* "relating to management and administration", a phrase which elsewhere in the *Act* is used with regard specifically to estates: see, for example, section 12. Query on this basis whether section 39 provides specific jurisdiction to appoint a committee of the person.

This difficulty is more apparent than real, as the definition of "mentally incompetent person" under section 1(e) of the *Act*, when read in conjunction with the common law discussed in other Appendices, would be broad enough to include persons who have become incompetent as a result of age. The relevant difference is that under this route, the individual would actually have to be labelled a "mentally incompetent person", a label which is perceived by some as rather distasteful. Section 39 allows the appointment of a committee without the indignity of the imposition of a label. Query how significant this distinction actually is.

It is submitted that the failure to include committees of the person as well as the estate in section 39 is an oversight. When section 39 was introduced in the early years of this century, the *Act* did not mention personal guardianship at all. When personal guardianship was explicitly introduced into the *Act* in the 1960s, section 39 was not amended. There appears to be no rational reason for the failure to make this amendment.

Act, and patients of those wards are covered by the provisions of the *Act*.²⁶² Of the institutionalized geriatrics aged seventy-five or older, -- presumably the group most likely to require the special provisions regarding competency determination provided by the *Mental Health Act*, -- only eleven per cent of the men and seven per cent of the women were resident in general or psychiatric hospitals in 1981.²⁶³

Nursing homes, homes for the aged, long-term care facilities and other institutions catering to the needs of members of the geriatric population are not covered by the *Act*. While these institutions may be heavily regulated administratively, the relevant legislation does not affect issues regarding patient rights, competency, and patient autonomy in a manner of any significance to the Enquiry. The result is an apparently arbitrary distinction in the geriatric population. Many of the institutions not covered by the *Mental Health Act* offer services largely similar to the psychogeriatric wards which are affected by the *Act*, and whether a person is placed in a psychogeriatric ward or some other facility may in many cases be a largely arbitrary decision. The result of this decision, however, greatly affects the legal rules applicable to the affected individuals.

In addition to these legal structures, senior citizens are surrounded by a panoply of government programs and social services. While an understanding of these programs is useful to understanding the decision making context in which issues of competency arise, they do not themselves directly refer to the capacity of the individual, and an in-depth review of these programs is not necessary here.

B. MYTHS AND REALITIES OF GERIATRIC CAPACITY

There is a persistent image of the geriatric man or woman as being vulnerable, physically and mentally decaying, living in misery, either in an institution or alone in squalor. The emotional appeal of arguments to limit the autonomy of the geriatric population through findings of incapacity depends largely on the frequency with which this image in fact represents reality. It therefore becomes necessary to give serious consideration to the characteristics of the senior

²⁶² Patients in public hospitals are also covered by regulation 865 under the *Public Hospitals Act*. As discussed elsewhere, it is highly ambiguous what that regulation means, if anything, and indeed whether it is valid at all.

²⁶³ *Ibid* at 75. The figure refers to all of Canada, and not merely to Ontario. The remaining eighty-nine per cent of men and ninety-three per cent of women were lodged in religious institutions, special care homes, nursing homes, homes for the chronically ill, and various other institutions.

population. These characteristics are also important in understanding the decision making context in which issues of capacity arise.

There are some facts which support the image. Certainly, seniors are statistically poor, a factor which creates vulnerability. Half of the families with heads over age 65 had annual incomes under \$15,000 in 1981, while only fifteen per cent of families whose heads were not seniors had a similarly small income.²⁶⁴ Of seniors who were "unattached", fifty-seven per cent had 1981 incomes under \$7,000.²⁶⁵ Women are statistically poorer than men. In 1980, fifty-seven per cent of senior women had incomes of less than \$5,000 per year, and seventy-one per cent of less than \$6,000 per year.²⁶⁶ Women outnumber men in all age ranges over sixty-five, and this disparity becomes more pronounced as higher age ranges are considered. This trend is expected to become more pronounced in the foreseeable future, such that by 2001, there are expected to be twice as many women as men over the age of eighty.²⁶⁷ This eventuality would suggest that problems of geriatric poverty will persist.

There is evidence of physical difficulties of senior citizens. Weissman's survey of 2,588 seniors living in New Haven evaluated functional abilities. Eight per cent of the sample indicated that they required assistance with personal care, and thirty-three per cent responded that they needed assistance with mobility. The remainder responded that they were largely independent. Perhaps more disturbing, Weissman asked how often they relied on friends for social support: twenty-six per cent indicated that they had no close friends nearby.²⁶⁸

Increasingly over the last ten years, society has become aware of the problem of elder abuse. While statistics are by their nature difficult to collect, it has been estimated that roughly one million American seniors are the victims of

²⁶⁴ *Fact Book* at 42.

²⁶⁵ *Ibid.* "Unattached" in this context means living alone or in a household where he/she is not related to the other household members.

²⁶⁶ P. Bartlett "Sexual Distinctions in Pensions". (1986) 24 *Osgoode Hall Law Journal* 833 at 838.

²⁶⁷ *Ibid* at 20.

²⁶⁸ M. Weissman, J.K. Myers, G.L. Tischler, C.E. Hoizer *et al* "Psychiatric Disorders (DSM-III) and Cognitive Impairment among the Elderly in a U.S. Urban Community". (1985) 71 *Acta Psychiatrica Scandinavica* 366 at 371. The figure concerning mobility corresponds almost exactly to the corresponding statistic in the *Fact Book*, which found that in 1981, the major activity of 36 per cent of men and thirty-four per cent of women had been partially or totally limited at some time in the previous twelve months. The corresponding figure for the population aged 15 to sixty-four was nine per cent: *Fact Book* at 56.

moderate to severe abuse annually.²⁶⁹ Most of the abusers are family members. Most frequently, the abuse involves either taking financial advantage, or the neglect of the needs of the senior.

Consistent with the image portrayed in these statistics, a greater than average proportion of seniors are inadequately nourished.²⁷⁰ Also, predictably, seniors are hospitalized with physical difficulties more frequently than the population as a whole.²⁷¹

The bleakness of this picture must be tempered somewhat. The Weissman study, for example, reported that over ninety per cent of the seniors surveyed considered themselves to be in at least fair health, and over ninety-six per cent considered themselves to be in at least fair emotional health.²⁷² Considering the image outlined at the commencement of this section, the individual is unlikely to be in misery, unlikely to be living either alone or in an institution,²⁷³ unlikely to be particularly physically or mentally decayed. It is clear that the situation of senior citizens raises broad social concerns; it is not clear that a paternalistic approach is required.

The bleakness of the picture does not relate directly to capacity. When factors related to capacity are considered, a very different picture emerges. A study by Folstein of 3481 adults living in the community in east Baltimore found that only 6.1 per cent of persons over sixty-five years of age were suffering from some form of dementia. Of those over the age of seventy-five years, less than twelve per cent were suffering from any form of dementia, and only two per cent of those between sixty-five and seventy-four were subject to dementia.²⁷⁴ A study

²⁶⁹ D. Shell *Protection of the Elderly: A study of Elder Abuse* (Winnipeg: Manitoba Council on Aging, 1982) at 1.

²⁷⁰ *Fact Book* at 53. This is particularly true of senior men.

²⁷¹ The *Fact Book* reports that in 1978-79, eighty-six per cent of people aged sixty-five and over reported having at least one health problem, compared with about half of those under age sixty-five. The most frequent health problems in seniors were arthritis, rheumatism, hypertension, hearing disorders, sight disorders, and heart disease: *Fact Book* at 58.

²⁷² M. Weissman, J.K. Myers, G.L. Tischler, C.E. Holzer *et al* at 371.

²⁷³ Only nine per cent of those over the age of sixty-five were resident in so-called "collective dwellings" in 1981. By the age of seventy-five, twenty per cent of women are living in such establishments: *Fact Book* at 68.

²⁷⁴ M. Folstein, J.C. Anthony, I. Parhad, B. Duffy and E.M. Gruepberg "The Meaning of Cognitive Impairment in the Elderly". (1985) 33 *Journal of the American Geriatrics Society* 228 at 232.

by Feinson concludes that age is not a factor in the prevalence of depression and distress.²⁷⁵ The Weissman study presents a picture not quite so pleasant, but still not dismal. Just under eleven per cent of Weissman's sample of seniors suffered from either a DSM-III disorder or severe cognitive impairment at some time during the six-month length of the study. Weissman presents the following statistics as to age distribution of such impairment:²⁷⁶

Age	Severe Cognitive Impairment (%)	Other DSM-III Diagnosis (%)	Total (%)
65-74	1.1	7.3	8.4
75-84	4.3	6.3	10.6
85 +	16.8	3.3	20.1

Weissman also records that twenty-six per cent of respondents acknowledged having a memory problem, a factor which, in extreme cases, could limit capacity.

Regarding the geriatric population as a whole, therefore, the majority of this group in every age category surveyed are apparently capable of making their own decisions. We should not lose track of this basic fact, notwithstanding the social problems which the members of the geriatric population face, and notwithstanding the more complex environment of institutionalization.

The problems of the institutionalized are different, both because they may be expected to be more likely of marginal capacity than the general population of seniors, and because of the effect of the institutional environment. The dependence on the institution and its staff for all activities of daily living can itself create an environment in which the resident becomes less involved in the decision making process. The result is an adverse effect on the emotional, physical, and behavioural well-being of the resident. It has been argued that the fact of institutionalization itself has a negative impact on capacity.²⁷⁷

²⁷⁵ M. Feinson "Aging and Mental Health: Distinguishing Myth from Reality". (1985) 7 *Research on Aging* 155.

²⁷⁶ M. Weissman, J.K. Myers, G.L. Tachler, C.E. Holzer *et al* at 373.

²⁷⁷ A. Caplan "Cries and Whispers: Ethical and Policy Issues Raised by Impaired or Diminished Competency in Elderly Patients". In E. McGee and G. Gutman *The Challenge of Time*, being Volume V of the *Canadian Gerontological Collection* (Winnipeg: Canadian Association on Gerontology, 1985) at 174; see also B. Hoffland "Autonomy in Long Term Care: Background Issues and a Programmatic Response". (1988) 28 (Suppl.) *The Gerontologist* 3 at 5.

Society continues to uphold its stereotypes of old people. The image described at the beginning of this Appendix was one such stereotype. Cohen argues that these stereotypes are the result of a social view which perceives the geriatric population as biologically inferior to the remainder of society. He argues that these images continue to be largely unchallenged in society as a whole and in the geriatric population itself. As a result, the success of the geriatric "liberation movement" has been much more restricted than that of the other liberation movements. The geriatric population, he argues, have themselves bought into this perception, resulting in a decreased functional autonomy in that population.²⁷⁸ He points out that if this is true in the geriatric population as a whole, it is likely to be even more pronounced in an institutional setting.

The major competency related issue affecting institutionalized seniors concerns "over care". The concern is that persons who are not capable are being over-medicated or otherwise denied an appropriate degree of autonomy. A recent Manitoba experiment provides some indication that such concerns may be justified. Between 1980 and 1983, the St. Boniface Hospital reduced mechanical restraints on geriatric patients from 2,777 to 97. There was also a reduction in the amount of psychotropic medication administered to these patients. Notwithstanding the reduction, there was no significant increase in falls requiring medical attention.²⁷⁹ This would suggest that facilities may be over-zealous in protecting the senior, and in fact be unjustifiably restricting the rights of the senior. The point is stronger regarding any over-medication, because such medication may have harmful adverse effects and thus not merely be an unjustified restriction on patient autonomy, but also directly harmful to the individual.

Insofar as the difficulty relates to the "elderly mystique", the self-perception of some members of the geriatric population of their inability to make decisions as a result of institutionalization, an effective program of returning control to the patients would be the obvious solution. They must be given their rights, not only in law, but in practice. And as with children, they should be involved in the decisions which affect their lives to the greatest amount possible, whether or not they are technically capable.

²⁷⁸ E. Cohen "The Elderly Mystique: Constraints of the Autonomy of the Elderly with Disabilities". (1988) 28 (Suppl.) *The Gerontologist* 24.

²⁷⁹ A. Schafer "Guarding the Liberty of the Aged", *Globe and Mail*, July 5, 1985, at 7.

At least some of the residents of the institutions, however, are going to be incapable. An effective administrative system is required to determine incapacity and allow for a substitute decision maker to make the required decisions on behalf of the patient.

The "over-care" concern may also affect some of the geriatric living in the community. There is some suggestion, for example, that chemical treatments may be over-prescribed in this group as well, and particularly over-prescribed to older women.

The greater concern, however, relates to under-care of the senior in the community, the fear that the senior is not receiving adequate personal care, for example. Also of concern is the frequency of abuse, be it financial, by way of neglect, or, less frequently, by direct assault. These concerns are to be measured against the intrusion into the private life of the individual. Ironically, one form of financial abuse can ensue when a family member is appointed committee of the estate and fails to adequately provide for the senior. Alexander refers to these people as "wards of their own wealth",²⁸⁰ persons who have lost their liberty as a result of an attempt, well-intentioned or otherwise, by the courts and their families to ensure that they not lose their wealth. Once again, it is to be recognized that these issues, while related to capacity, will often have other factors inextricably bound up with them. The senior may feel, for example, that he or she cannot challenge the person taking financial advantage of him or her because living with that person is perceived as more desirable than living in an institution or on the street, the other available options. The consideration of decisional capacity must recognize the existence of these other factors if the desired result is to be achieved.

C. ASSESSMENT OF CAPACITY IN THE GERIATRIC POPULATION - SUMMARY

Given the unique characteristics of the geriatric population, we recommend that the same parameters be used to assess them as are used to assess the general population, with some minor changes in emphasis. The following summarizes our recommendations in this regard:

- 1) Cognitive parameters, though necessary, should not be as heavily weighted when assessing decisional capacity in this population unless cognition is so

²⁸⁰ G. Alexander "On Being Imposed Upon by Artful or Designing Persons". (1977) 14 San Diego Law Review 1083 at 1084.

compromised as to prevent adequate functioning.²⁸¹ Also, cognitive tests would be useful for differential diagnoses in order to rule out reversible dementia or delirium.

- 2) Self-functioning is an especially important parameter when assessing the decisional capacity of the geriatric population. There are a variety of tests²⁸² available and mechanisms such as those employed by the geriopsychiatric outreach team²⁸³ and the Baycrest Competency Clinic²⁸⁴ that can be used to assess this parameter.
- 3) Sedimented life preferences become particularly important when an issue arises regarding the lifestyle and living arrangements of a geriatric person. Sedimented life preferences are the established patterns of behaviour and choices of the geriatric person. Choices that comport with an individual's life preferences should be recognized in the absence of serious cognitive or functional deficits.²⁸⁵
- 4) Decisions around the technological extension of life, which primarily but not exclusively involve geriatric decision makers, introduce a topic of increasing importance in society. The living will is a document in which it is stated by the patient that should his or her condition be judged irreversible or hopeless by a competent physician and should he or she no longer be mentally capable of making decisions, that "heroic" means should not be used to prolong life. The living will instructs an individual's physician and family

²⁸¹ Recognition should be given to the fact that we do not have a precise notion of what is meant by a psychiatrically normal person since cognition is usually measured in reference to the prototypic middle-aged adult. Furthermore we have no clear sense of what type and level of cognitive functioning is required for individuals in this group to operate in their social and cultural setting.

²⁸² See E. Pfeiffer *The OARS Multidimensional Functional Assessment Questionnaire* (Durham: Duke University Centre for Aging and Human Development, 1975) and 5-15; I. Rosman "Comprehensive Functional Assessment: A Commentary". (1983) 21 *Journal of the American Geriatric Society* 763; and S. Katz "Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living". (1983) 31 *Journal of the American Geriatric Society* 721.

²⁸³ See M. Wolff "Determination Mental Status in an Ambulatory Geriatric Population". (1984) 32 *Journal of the American Geriatric Society* 245 and M. Williams and T. Williams "Evaluation of Older persons in the Ambulatory Setting". (1986) 34 *Journal of the American Geriatric Society* 37.

²⁸⁴ See M. Silberfeld, W.R.C. Harvey, B.M. Dickens and R.J. Pepper-Smith "A Competency Clinic for the Elderly at Baycrest Center". (1988) *Advocates Quarterly* 23.

²⁸⁵ See V. Meinick and N. Dubler, (eds.), *Alzheimer's Dementia: Dilemmas in Clinical Research* (Clifton: Humana Press, 1985).

that he or she would prefer death to artificially continuing life when there is no hope of recovery.

The living will resembles a testamentary document. It is notarized and at least two witnesses are present. It is made with the intention of safeguarding the patient against the influence of pain or future family financial ruin at the time the document is executed. As an advance declaration, it signifies the competence of the declarant. This notion that people may, in advance, ameliorate at least some of the details of their passing has become widespread. A patient's right to an informed consent makes no sense if the right does not extend to allow him or her to decide to refuse. Such a right should be open to the dying patient. If the maker of the will is subsequently adjudged incapable, the will would be revoked. In creating the document, it is the intention of the drafter to cover contingencies wherein he would be able to grant or withhold consent to treatment, which would include incapacity due to mental illness.

The living will is meant to be a persuasive instrument directed toward the family and physician. Its presence may encourage the family to agree to the end of treatment while providing a defense for the physician in the event that a suit is initiated.

A fuller discussion of certain artificial extensions of life (termination of life support, living wills and durable powers of attorney) are outside the scope of this report. We would, however, recommend that further study be carried out to explore the legislative implications of these issues.

XIII. TESTING DECISIONAL CAPACITY

A. LIMITATIONS ON THE VALIDITY OF EMPIRICAL STUDIES ON COMPETENCY

Over the past 20 years there has been an increasing reliance on epidemiologically derived data regarding the capacity of individuals to make critical decisions. Much of this research has been focused on informed consent which emerged as a legal theory in the late 50s. Studies of the determinants of individual capacity for entering into treatment decisions have proliferated, particularly in the last ten years, in response to the momentum of informed consent and consumer demands, generally, for greater decision making prerogatives in the health care system. This research has resulted in data that has not only been used to influence policy and legislative decisions, but has also buttressed positions and holdings in court cases.

Cases involving law and medicine, particularly with respect to mental capacity, have even reached the United States Supreme Court in recent years. Until 1975, no decisions had been made by the United States Supreme Court that involved, for example, the practice of psychiatry in the civil setting.²⁸⁶ Since that time there have been at least six such decisions and the court is beginning to demand more rigor for data rather than reliance on expert opinion alone. Such rigor is achieved through the use of empirical studies which produce statistical statements that can be packaged to give at least the appearance of being closely reflective of the real world. In no area of examination has this been more problematic than in the area of capacity to make social decisions. Many studies have been done specifically on this issue in the past several years and they are frequently fraught with methodological and ideological biases.

This discussion will explore the problems of interpretation of empirical findings with a particular emphasis on the role of ideologies in epidemiological research. In order to achieve this objective, the discussion will focus on two questions for analysis. First, does the data from research meet the statistical requirements of a solid epidemiological study. To answer this question it will be necessary to review study designs and methods for gathering and interpreting data. The second question focuses on the underlying framework of a study, that is, the nature of those conducting the study, what ideologies dominate, either explicitly or implicitly, and the extent to which the research constructed to achieve this goal is shaped to reaffirm such ideologies.

²⁸⁶ P. Appelbaum "The Supreme Court Looks at Psychiatry", (1984) 141 Am. J. Psychiatry 827.

This discussion reviewing competency studies will be concerned especially with the latter level of analysis, but will still address some of the issues relevant to the first question. It will seek to demonstrate, however, that the methodological features of analysis alone are insufficient for establishing the meaningfulness of data, and that the second level of analysis is essential for elucidating the influences of preconceived values or ideologies on the results of a study, and especially on the way data is interpreted. This issue becomes important in our examination of affirmative statements regarding the capacity of various segments of the population, particularly children, the mentally disordered, and the geriatric population.

Since many of the studies applying epidemiological methodology to competency involve the health care system, this review will focus on specific sets of data from that area of decision making. To some extent the full range of issues on competency will not be specifically addressed, but what has happened to data in the health care system is relevant to what would happen to competency studies of the non-sick engaged in a series of civil decisions from signing a will to enacting a contract agreement. Hence, the disclosure of methodological and ideological problems is relevant to how empirical research results should be used in determining capacity to make social decisions.²⁸⁷

An important feature of most research that intersects at the law/psychiatry and psychology realm is the examination of decision making processes of certain objectives incorporating broad notions such as "competency" and "rational consent." These would apply to such issues as agreeing to be a research subject, refusing treatment, giving informed consent, and determining cognitive capacity to function in society. We will begin this study first by reviewing frequently occurring errors and their impact on methodology and will then follow that with a brief discussion of the issue of ideology as it applies to the construction of research studies.

1. Methodological Errors and Their Impact

Psychological and social scientific inquiry is governed by a set of guidelines which, however, remain flexible so as to account for the diversity of human behaviour. Nonetheless, scientists must observe universal rules if the results are to be valid and reliable. Many of these rules have been largely ignored in mental

²⁸⁷ L.R. Tancredi and D.N. Weisstub "The Ideology of Epidemiological Discourse in Law and Psychiatry: Ethical Implications". In L.R. Tancredi (ed.) *Ethical Issues in Epidemiologic Research* (New Brunswick: Rutgers University Press, 1986).

health research and thereby are responsible for some of the conceptual problems and inaccuracies of such research. The following is a brief discussion of some of the guidelines that are critical for solid research results.

Operationalization

It is essential to set parameters that define or describe a concept prior to its being subjected to empirical investigation. Operationalization refers to the development of specific research procedures or operations that will result in empirical observations representing those concepts in the real world. Despite the fact that it is essentially impossible to conduct meaningful research without fully understanding the object of the research, few investigators adequately operationalize key concepts. It is possible that, on the one hand, the concept is thought to be so simple that knowledge of its meaning is assumed to be part of conventional wisdom; on the other hand, the concept may be so complex as to defy description. This lack of a clearly articulated object is particularly pervasive in studies conducted in the mental health area. Without a clear conception of what is being studied, the data that is obtained may not relate to the concept in any meaningful way. This insufficiency would essentially invalidate research results and confound conclusions that are drawn from these results.

Control

To control or rule out the effects of an experiment itself, a control group is necessary. The need for a control group was demonstrated in studies undertaken by Roethlisberger and Dickson in the 1930s at the Western Electric Hawthorn Works in Chicago.²⁸⁸ These studies were aimed at identifying changes in working conditions which would improve employee satisfaction and productivity. Researchers determined initially that when lighting in the workroom improved, productivity increased. Further improvements in the lighting resulted in further increases in productivity. Roethlisberger and Dickson then dimmed the lights and expected a decline in productivity. However, surprisingly, productivity again improved. Researchers concluded that the workers were not responding to the improvements in working conditions, but instead were responding to the attention given to them by the researchers. This phenomenon, referred to as the Hawthorn Effect, has generally served to make researchers cautious about the possible effects of the experiment itself.

²⁸⁸ J.J. Roethlisberger and W.F. Dickson *Management and the Worker* (Cambridge: Harvard University Press, 1939).

Unfortunately, sensitivity to the Hawthorn Effect does not appear to have extended to research in the mental health field. Many studies are undertaken without control groups and little mention is made of the fact that the results of the study may be compromised or affected by the absence of these groups. There are probably circumstances that make it impossible or infeasible to establish control groups in some experiments involving mental health. However, some effort should be made to use comparison groups, or alternatively, to acknowledge the possibility that the results of the experiment will be affected by the absence of control.

Objective Investigation

Studies in the area of informed consent, in particular, are conducted by investigators who are intimately involved in the process they are attempting to study. Frequently, studies are conducted on research participants who are simultaneously patients under the care and treatment of the physician conducting the research. Investigators who assume this dual role, that of physician and researcher, are in a sense studying their own behaviour. They lack the detachment which is necessary to lend credibility to their findings. They are unlikely to view their own behaviour in terms of its relative impact on their clients' behaviour. Therefore, it is unlikely that they will assess the effects of their own behaviour in the same light that a neutral observer would.

The physician acting in the dual role of physician/researcher may affect the behaviour of research participants simply by virtue of his status as their physician. For illustration, clients who would refuse to participate in a research study conducted by a disinterested third party may feel obliged, or even pressured, to participate when the researcher is also their physician. It is highly plausible that such an effect may occur. By the same token, it is virtually impossible to predict its direction. This in turn makes discounting for its existence an extremely problematic, if not impossible, undertaking.

Hypothetical Scenario

The use of hypothetical scenarios are seen in analog studies wherein the study participants are required to make hypothetical decisions related to hypothetical procedures. There are some inherent advantages in this methodology - primarily it affords the investigator the ability to control many extraneous variables. But, there are also disadvantages -- analog studies are susceptible to a lack of verisimilitude and this must be noted when interpreting findings. For

example, the possibility for invalidity exists because subjects will inevitably experience an absence of many of the psychological components of decision making which may otherwise be present if the decision would have had some impact or consequence in an actual test situation. Since research participants are not confronted with the cognitive challenges of reality, they may be unable to accurately predict how they would respond if they were functioning in this scenario. Also, individuals making hypothetical decisions may pay a different degree of attention to disclosure -- be it more or less -- than they would if they were actually confronted with the situation. As it is often impossible to measure either the difference in the degree of attention or the degree of variation, it is also difficult, if not impossible, to control for it.

"Recall" Studies

Recall studies are those studies whereby a failure of the subject to recall certain information is viewed by the researcher as proof of the concept under investigation. These studies pose problems, particularly with regard to competency. In these studies, a failure to recall information is perceived as *prima facie* proof of incompetency to consent to or refuse treatment. This point is illustrated by Meisel and Roth:

That patients do not recall information several days, weeks, or months after treatment is simply not relevant -- or at best marginally relevant -- to whether or not they can be said to have rendered an informed consent at or near the time of the procedure.²⁰⁰

Poor recall may simply be a function of a normal forgetting process. This point is generally overlooked in the "recall" literature. In the absence of a control or, at the very least, a matched comparison group to indicate the contrary, it is plausible that psychiatric clients may actually recall more than other groups of patients would remember. There is, however, currently no way of proving or disproving this notion because of the systematic failure to perform control studies in this area. Moreover, it is interesting to note that researchers frequently question whether the subjects understand and/or recall what they have either read or been told without bothering to ascertain whether the patient had, in fact, reviewed any information in the first place. Most often it is merely assumed that he had!

²⁰⁰ A. Meisel and L.H. Roth "Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies". (1983) 25 Arizona L.R. 308.

Where disclosure is supposed to be made to patients by someone other than the investigator conducting the informed consent study, which for other methodological reasons ought to be the case, it is incumbent upon the investigator to determine whether in fact disclosure has been made.²⁹⁰

2. Two Specific Studies Revealing Methodological Errors

To illustrate some of the methodological problems of research studies particular to the mental health field, two specific studies will be evaluated in depth. The first is a study examining the information base of schizophrenic patients in long term treatment.²⁹¹ The second study is an examination of the characteristics and outcome of patients who refuse medication.²⁹² Both of these studies deal with mental patients and attempt to examine certain characteristics of these patients. In the first study, the attempt is to examine the capacity of schizophrenic patients to recall certain information about their therapy. The second study is to examine the nature of those patients in a psychiatric facility who are refusing medication. The critique of these two studies will demonstrate some of the methodological problems inherent in studies involving the mental health field and point to aspects of those areas that could be rectified.

The first study was an examination of schizophrenic patients who had been in therapy for many years. These patients were interviewed about the information they had received during their therapy. The researchers in this study hoped that a systematic assessment of the information these patients possessed would serve as a point of reference for discussing legal and therapeutic demands more specifically and in greater detail.²⁹³

The method employed in this study involved 85 outpatients of the Department of Psychiatry at the Free University of Berlin. They were interviewed by the researchers. All patients who were asked to participate in this study consented to do so. The attending psychiatrists had diagnosed all the participants as being afflicted with one of the schizophrenic disorders. The researchers used a

²⁹⁰ *Ibid.*

²⁹¹ M. Linden and R. Chaskel "Schizophrenic Patients in Long-term Treatment". (1981) 7 *Schizophrenic Bulletin* 372.

²⁹² R. Kenling "Characteristics and Outcome of Patients who Refuse Medication". (1983) 34 *Hospital and Community Psychiatry* 847.

²⁹³ M. Linden and R. Chaskel "Schizophrenic Patients in Long-term Treatment". (1981) 7 *Schizophrenic Bulletin* 372.

detailed interview guide and questionnaire, the average interview taking between 15 to 20 minutes.

The results of the study indicated that when the participants were asked which side effects their drugs might have, 40 per cent could not name a single side effect. One per cent named 1, 23 per cent named 2 to 3, and 6 per cent named 4 or 5. The patients were then given a list of 37 typical side effects of neuroleptics and other drugs, which were delineated in both the lay and scientific terminology. The mean number of side effects selected by patients as effects they had personally experienced was 6. When they were asked why they needed medication or what benefits they hoped the medication would have, 85 per cent mentioned at least one therapeutic effect spontaneously. Thirty-nine per cent of these individuals indicated that the drugs were taken to prevent relapse. When they were shown a list of 37 therapeutic effects and asked which effects they had experienced, patients indicated a mean of 12. Much to the researchers' surprise, 93 per cent of all drugs prescribed were named correctly by the patients. Eighty per cent of the respondents perceived that generally patients were adequately informed; however, only 54 per cent felt that they themselves had been adequately informed about therapy.

Based on the data collected, the researchers concluded that "these findings cast considerable doubt on the usefulness of formal legal demands concerning information given to patients".²⁸⁴ The researchers then differentiated between consent in terms of a patient voluntarily following a course of treatment and what they termed "real" consent -- knowledge of medical facts.

The critique of the research study is as follows: Although the authors allude to the fact that the population study was a highly compliant one, the fact that all subjects who were asked to participate consented prompts one to question the validity of the sample. The research subjects were also patients under the care of the researchers. Thus, there is a high probability that the pre-existing patient/physician relationship had a dramatic impact on the consent elicited to participate in the research project. Further, there was a great opportunity for researcher bias to enter at this initial stage. It is possible that the sample group was hand-picked by the researchers to provide desired results, as may be inferred from the fact that all the patients who were asked to participate, consented.

²⁸⁴ *Ibid.*

The study was undertaken without any attempt to control for extraneous variables. Conventional wisdom dictates that similar results would be found in any patient population, particularly with regard to knowledge of medication side effects. This study does not demonstrate that psychiatric patients are any less informed than any other group of patients. The subsequent conclusions are somewhat diluted; they cannot provide a basis for any meaningful generalizations.

The researchers utilized a one-shot rather than a time-sequence or longitudinal methodology. Since the patients were hospitalized for long terms (10 years), it is possible that this time frame had an effect on the patients' recall. Consent may have been informed at one time, but the patients had subsequently over a period of time forgotten these details. Additionally, the extent of the controversy regarding consent has increased in recent years. It is possible that patients entering the system more recently are better informed by physicians than patients had been in the past. The problem with the study is that the methodology employed does not exclude these or other potentially confounding variables. Therefore, the study is of very limited and questionable value. Even if one were to overlook many of the methodological flaws, the study would lack in reliability - the results are simply not applicable to any other group. Furthermore, the research also suffers from a lack of internal and external validity.

The second study reviewed involved characteristics and outcome of patients who refused medication.²⁹⁵ In this study the authors attempted to study patients from a clinical perspective and to answer the following questions: Who are these patients? What diagnostic categories are represented? How do they respond to treatment?

The researchers obtained their sample from a group of 375 patients who represented admissions to the civil division of a Washington, D.C. hospital during a 5-month period. In this group, 9 patients representing less than 2.5 per cent of the population, required a determination regarding whether or not involuntary medication could be given. All 9 patients were found to meet the hospital's criteria for emergency medication. The emergency medication criteria consisted of two parts. First, the patient must be found incapable to make a rational treatment decision; second, the patient must pose a danger to himself or to others. Subsequent to this determination, one dose of a long acting phenothiazine was administered. After two weeks, all patients were accepting medication voluntarily.

²⁹⁵ R. Keisling "Characteristics and Outcome of Patients who Refuse Medication". (1983) 34 Hospital and Community Psychiatry 847.

The brief psychiatric rating scale (BPRS) and the global assessment scale (GAS) were administered both at the time of the initial consultation and two weeks later. The same rater administered the test each time.

The results of this study were as follows: All nine of the medication refusers were involuntary admissions, and seven of the nine were men. The average age of the group was 33. At the time of the medical director's initial consultation, the nine patients' average global BPRS rating was 10.4. This rating was measured on a scale ranging from 0 to 12, with 0 indicating the least pathology. The average GAS rating was 12.7. This rating was on a scale of 1 to 100 with 100 indicating the highest level of functioning. After two weeks, the average BPRS had improved to 4.1 and the group's average GAS rating had increased to 48.3. The average length of hospitalization for the 9 patients was 43 days. The researchers, based on this data, concluded that "delay of treatment probably would have resulted in prolonged hospitalization perhaps for a month and possibly in life-threatening behaviour".²⁹⁶ They further stated that "treatment delay probably would have resulted in a loss of jobs or description of careers for most of the patients".²⁹⁷

Critique of this study revealed that it is plagued with methodological errors. There was neither a control group nor comparison group and, therefore, it is unclear whether the changes in the BPRS and the GAS scores are attributable to the medication or to some other intervening variable, such as researcher attention. Furthermore, the sample size is so small that even in the presence of an adequate control, the results obtained could not be asserted with a high level of confidence, nor would they be generalizable. If the researchers were aware of the hypothesis to be tested, which appears to be the case, changes in the BPRS and the GAS scores could be partially attributable to researcher bias -- the same researcher conducted both sets of tests. More specifically, the conclusions are not in any way related to the results obtained nor are the results supported by the data. Also, the conclusions do not follow in any significant way from the researcher's hypothesis. In fact, one may rightly state that the study does nothing other than illustrate that the researchers were unaware of even the basic principles that must be followed when undertaking social scientific research. The results are essentially invalid and completely unreliable.

²⁹⁶ Ibid.

²⁹⁷ Ibid.

To appreciate the methodological problems of this study, it might be useful to contrast same with a research project that attempted to address the identical set of issues. That project examined the "clinical characteristics of hospitalized psychotic patients who refuse antipsychotic drug therapy".²⁹⁸ The purpose of this study was to undertake a retrospective study of protracted refusal, which is defined as continued total non-compliance with a drug regimen.

The researchers retrospectively examined the records of 30 consecutively committed psychiatric patients whose treatment teams had requested non-emergency forced medication and who had been approved for forced antipsychotic therapy by the treatment review panel. A sample of 30 consenting patients who had willingly accepted antipsychotic medication, was matched for age, sex, treatment unit, commitment status, and diagnosis of a major mental illness that frequently required an antipsychotic agent. This selection was designed to minimize the potential for confounding of non-specific factors such as treatment teams, clinical staff, and drug dosage decisions. The researcher who was responsible for abstracting data on demographics and psychiatric variables from the patients' medical records was unaware of the hypothesis being tested. The data on non-compliance or disruptive behaviour that were of interest to the researchers were extracted from a review of weekly nursing summaries, psychiatrists' notes, and order sheets for the month immediately preceding the researcher's visit. In order to validate the reported assaults, the researchers also reviewed the nursing supervisor's monthly assault reports. A high concordance between sources was discovered.

The data indicated that drug refusers were generally young (73 per cent), male (63 per cent), white (87 per cent), single (63 per cent), and had achieved a high school education (60 per cent). No significant differences were found between refusers and consenters on the unmatched variables which were compared. Seventy-three per cent of the refusers and 87 per cent of the consenters had four or more previous hospitalizations for psychiatric reasons. Furthermore, there were no statistically significant differences discovered between refusers and consenters in the frequency of previously-recorded episodes of threatening or assaultive behaviour. In contrast, significant differences were observed in the category of mental illness between the two groups. More refusers were given a diagnosis of bipolar or schizo-affective disorder, while the majority of the consenters were diagnosed as having schizophrenia.

²⁹⁸ J.M. Zito, W.W. Routt, J.E. Mitchell and J.L. Roerig "Clinical Characteristics of Hospitalized Psychotic Patients Who Refuse Antipsychotic Therapy". (1985) 142 *Am. J. Psychiatry* 822.

The researchers found that as a group, the refusers did not display more threatening, assaultive or destructive behaviour, nor did they demonstrate greater non-compliance with other parts of the treatment program. These results were observed despite the fact that the refusers had been medication-free for the month preceding the treatment review panel's visit. Based upon this, the researchers concluded that other techniques or approaches were used effectively by the hospital staff and that an observation of such a staff-patient interaction is an important aspect of future research. The researchers further concluded that the differences in the groups may be a function of their type of illness. The refusers were more often characterized as bipolar or schizo-affective, and therefore, underlying the refusal may be the manic patient's preference for the hypomanic state.

In contrast to the majority of research involving this patient population, this study is scientifically sound with reference, in particular, to its use of a matched control group. This is not to give it unqualified endorsement, but it can at least be utilized as a model for future research. The main limitations of the study are the retrospective nature of its design and the small sample size utilized. A low incidence of many of the targeted behaviours suggests that such behaviours are not sensitive or accurate predictors of medication refusal. Therefore, other measures should be considered for future research. If no differences become apparent then it may be the case that negative behaviours do not discriminate between refusers and consenters. A prospective study technique utilizing blinded time-sampling of behaviours is an alternative methodology which may enhance validity.

Summary of Studies

From the examination of these research studies it appears that the methodological flaws in mental health research do not appear to be overly complex. Nonetheless, flaws continue to proliferate in the literature. Lawyers, physicians, and social scientists alike, undertake and then report methodologically poor studies. Legal and medical journals continue to publish these studies even though some of them are completely unworthy of publication.²⁹⁹ Once published, these studies are erroneously legitimized. Within the mental health literature, researchers continue to cite approvingly the conclusions drawn, or results obtained by other researchers, all the while ignoring the patent defects contained within the studies. This has an amplified significance for two reasons. First and foremost, such research may be used as the basis for making treatment decisions or other policy decisions for the

²⁹⁹ L.R. Tancredi "Competency for Informed Consent: Conceptual Limits of Empirical Data", (1982) 5 Int. J. Law & Psychiatry 51.

mentally ill. It is ethically reprehensible that such decisions will be based on invalid, unreliable and completely ungeneralizable data. Secondly, courts are increasingly using social scientific research to aid in decision making. Given the invalidity and unreliability of the data and also the vicissitudes of the respective research literature, courts' increasing reliance upon it has profound implications.

3. Ideological Issues

The concept of ideology finds its roots in the 18th century when it contained pejorative connotations.³⁰⁰ It is possible, however, to characterize it less as a negative concept and more on how it functions as a neutral process of intellection. As pointed out by Romanucci-Ross and Moerman,³⁰¹ ideology can be seen as transforming "fundamental values into action." At the same time, ideology has retained some of its pejorative meaning in contemporary times. Marx, in *The German Ideology*, introduced the idea of false consciousness as a way of attacking liberal bourgeois ideas. Those following Marx' doctrine continue to use "ideology" to delegitimize political and economic positions that are clearly different from their own.

Many philosophers from the Frankfurt school have attempted to cast ideology in a less judgemental sense; thinkers such as Mannheim³⁰² viewed ideology in a non-valuative sense in suggesting that any social thought encased in a particular time and space is inherently ideological. The objective, therefore, of an ideological critique is less concerned with evaluating the correctness of a particular position or frame of reference and more with unearthing beliefs, values, and other underpinnings of society and the social life of a period.³⁰³

As we have pointed out already, there are basic concepts in much of legal psychiatric research that lend themselves particularly to ideological characterization. Most prominent of these are "competence", "rational consent", "autonomous decision making" and "criminal responsibility." These concepts are highly value-laden and, as such, create major problems for empirical studies since much of the research must be based on meanings and interpretations of terms that are connected with

³⁰⁰ J.B. Thompson *Studies in the Theory of Ideology* (Berkeley: University of California Press, 1984).

³⁰¹ L. Romanucci-Ross and D.E. Moerman "The Extraneous Factor in Western Medicine". (1988) 16 *Ethos: The Journal of Psychological Anthropology* 146.

³⁰² K. Mannheim *Ideology and Utopia* (New York: Harcourt, Brace & World, 1955).

³⁰³ G. Gurwitsch *The Social Frameworks of Knowledge* (New York: Harper and Row, 1971).

various belief perspectives. Despite these problems, however, few if any epidemiological studies dealing with broad concepts found in the mental health research seem to ever address their ideological foundations. Rarely does one see an explicit accounting of the beliefs underlying a study. The ideologies are pervasive in this type of research. Furthermore, once the reader is past the first sentence of a research article which elucidates the statement of purpose, he is unlikely to engage in a critical reading of underlying presuppositions.

The most important unexpressed presumptions of most studies are the following. First, studies generally assert a presumption of superiority which is the truth of their underlying belief system. Second, there is the unexpressed assumption of "identity of the framework," which essentially means that the study is compatible with some feature of truth and reality, particularly that of psychiatric truths as they relate to society generally.³⁰⁴ The assumption of identity of framework, of course, is essential for the conduct of any empirical study. Once a study is initiated, it is unlikely that one will continuously or even periodically re-examine the underlying framework of the information gathering process which is basic to the structure of research questions. On the other hand, once the empirical research has been accomplished, the findings and conclusions should be examined against the backdrop of questions regarding the identity of the framework.³⁰⁵

The third set of issues deals with the normative beliefs about the intrinsic features of studies. This topic consists of four sub-categories of issues: The first sub-category addresses whether the framework is the valuable means for empirical gathering of information. This essentially means that the symbols of meaning in mental health, symbols such as "disease," "competence," "instability", and "autonomy," provide specific examples from the universe of considerations affecting the information to be obtained. The second sub-category involves preconceived notions of what constitutes a good decision by research subjects in any particular study. For example, research on why patients refuse treatment would probably involve some belief by therapists of what constitutes a good decision by the patient. The underlying assumptions that would apply here would be that therapists have a good idea of what justifications would legitimize a deviant choice into a "good decision" and, secondly, that refusing treatment, in fact, requires justification. This also implies that if the patient accepts treatment, special justification would not be

³⁰⁴ R. Geuss *The Idea of a Critical Theory* (Cambridge: Cambridge University Press, 1981).

³⁰⁵ L.R. Tancredi and D.N. Weisstub "The Ideology of Epidemiological Discourse in Law and Psychiatry: Ethical Implications". In L.R. Tancredi (ed.), *Ethical Issues in Epidemiologic Research* (New Brunswick: Rutgers University Press, 1986).

required since acceptance is more consistent with the dominant power framework and therefore would appear reasonable and good to the investigators. The third sub-category of issues deals with research statistics, evaluations and conclusions, thus requiring that these three sets of circumstances are coherent and reasonable. This belief rests on the primary assumption that the basis for and conduct of the research are truly valuable, and that the framework for interpretation comports with the normative beliefs underlying the design of the study. The fourth subcategory is that of the assumption of integrity, which means, in effect, the researcher's state of mind and the extent to which it perjures in the text or presentation of the data, the evaluation and the ultimate conclusions.

A broad category that is frequently ignored is the one relating to the "doctrine of error." This doctrine refers to the presence of an intrinsic concept of what constitutes mistake or false ideology. To be effective, the normative beliefs of an ideology require that error be clearly identifiable. But this ideology of error is broader than mistake in the sense of methodological or statistical inconsistencies. It addresses errors in the conceptualizing, constructing and designing of studies. For illustration, different professionals interested in the same set of data would likely have different notions on whether their basic presuppositions result in useful information or error. A study conducted by civil rights oriented lawyers to assess capacity to refuse treatment would have a certain ideological thrust, different than a similar study conducted by psychologists. It would place the grid for differentiating competency from incompetency along a spectrum of conditions that would be legally defined to emphasize autonomy and self determination. The psychologists would create a grid of differentiation along a spectrum of conditions that would be psychologically defined. The ideology of error is essential for research because it creates the field of interpretation, mapping out the range of what would be considered reasonable as well as unreasonable results from the framework of that particular researcher.

In the area of experimentation and research, particularly where it deals with behavioral phenomena that intersect in various ways with law, a careful critique is essential to reveal the reasons behind basic findings of a research project as they address ideological concerns.³⁰⁶ An important feature of most of the research that intersects at the law/psychiatry realm is the examination of decision making regarding certain objectives, such as agreeing to be a research subject, giving informed consent, refusing treatment, and determining cognitive capacity to function in society. This, of course, calls for some presumptions about what is rational and

³⁰⁶ Ibid.

what is not rational. It seems to suggest that certain decision making approaches are better than others. In the following, we will examine a few studies in order to disclose the impact that ideological issues have on confounding the value of the conclusions from empirical research.

4. Specific Studies Revealing Ideological Problems

An example of a study that looked at the question of capacity to give informed consent is that of Weinstock, Copeland, and Bagheri.³⁰⁷ In this study, the authors reviewed the criteria for competency first suggested by Roth, Meisel, and Lidz in 1977³⁰⁸ and then reduced them to the basic notion that patients would be determined to be competent if they possessed the following qualities: 1) they are capable of expressing their choice; 2) a reasonable outcome is possible from the choice; and 3) the choice demonstrates that it is based upon rational reasons or, in other words, that a patient shows that he or she had actual understanding. These criteria were subsequently augmented by Appelbaum and Roth³⁰⁹ with the inclusion of a requirement that the patient's mental status be assessed over a period of time to determine what might be the underlying dynamics for refusal, if that occurs.

The study by Weinstock, Copeland and Bagheri involved 30 consultation requests which dealt with the issue of refusal of medical procedures.³¹⁰ Psychiatrists were asked to assess the capacity of the patients to give informed consent. The researchers developed their own method of assessing capacity which involved determining a threshold level of capacity based on the specific risks and benefits of medical procedures. Unless there was a life-death situation, the patients were allowed to make decisions that researchers would have otherwise considered unwise. They were also allowed to disagree with the physician if they were capable of weighing the risks and benefits of their decision. Where a life-threatening situation existed there was a rebuttable presumption that a competent patient would accept

³⁰⁷ R. Weinstock, R. Copeland and A. Bagheri "Competency to Give Informed Consent for Medical Procedures". (1985) 12 *Bul. Acad. Psy. Law* 117.

³⁰⁸ L.R. Roth, A. Meisel and C.W. Lidz "Tests of Competency to Consent to Treatment". (1977) 134 *Am. J. Psychiatry* 279.

³⁰⁹ P.S. Appelbaum and L.W. Roth "Clinical Issues in the Assessment of Competence". (1981) 128 *Am. J. Psychiatry* 1462.

³¹⁰ R. Weinstock, R. Copeland and A. Bagheri "Competency to Give Informed Consent for Medical Procedures". (1985) 12 *Bul. Acad. Psy. Law* 117.

the treatment. If, however, a patient refused the treatment he would be obligated to provide some justification. On the other hand, if the recommended procedure was risky with possibly uncertain benefits, the presumption would be rebuttable in the other direction -- that is, that a competent patient would refuse the treatment. However, the opportunity was provided for a patient who adduced "good reasons" to accept even the risky and questionably beneficial treatment.

The criteria of choice were based essentially on Roth's earlier criteria that the patient evidence a choice, that it be based on "rational reasons" and that he be capable of understanding those procedures that are being considered.³¹¹ The authors claimed that any patient who failed any of the tests, (including the one they added covering the patient's ability to retain this understanding),³¹² should be declared incompetent. Only patients with organic syndrome were actually found to be incompetent according to these criteria. Other patients, including those who were depressed, had schizophrenia, or suffered from personality disorder, or even no psychiatric disorder, were not found to be incompetent. Despite the various criteria that they used, the patients who were ultimately judged incompetent by the researchers demonstrated an inability to understand risks and benefits and to retain that understanding. Some of those patients who demonstrated these deficits were also judged incompetent because their choice did not seem to be based on "rational" reasons. However, the researchers quickly added that there were no patients who based their decisions on "irrational" reasons who also did not lack the ability to understand or retain the information. Of the 30 patients assessed for competence to give informed consent, 10 were viewed as incompetent.

Obviously one of the more important difficulties of this study is the inclusion of highly value-laden terms as "rational" reasons, or the patient "understood" specific procedures, or finally that he was able to retain the understanding. The concept of "rational" reasons is highly value-laden, if not wholly subjective.³¹³ What appears to be rational in one situation involving a refusal for treatment is based most often on how it fits with the researcher or treating physician's perception of what is "rational." No sharply defined criteria exist for assessing the rational state. In addition, whether a decision is found to be rational or not is frequently based

³¹¹ See F. Carneris "Crisis and Informed Consent: Analysis of a Law-Medicine Malocclusion". (1987) 12 *Am. J. L. & Med.* 55.

³¹² R. Weinstock, R. Copeland and A. Bagheri "Competency to Give Informed Consent for Medical Procedures". (1985) 12 *Bul. Acad. Psy. Law* 117.

³¹³ L.R. Tancredi "Competency for Informed Consent: Conceptual Limits of Empirical Data". (1982) 5 *Int. J. Law & Psychiatry* 51 at 53-54.

on the verbal capacity of the patient. A patient who is highly educated, that is, contains a good vocabulary, and can frequently justify in "rational" terms his particular preference. A patient with cognitive defects, or one less educated, may not be in a good position to articulate clearly the reasons for his refusal of treatment, though the intensity of belief and desire may be as strong and valid as in the former case.³¹⁴

Similarly, the concept of the patient's ability to "understand" is problematic because we do not have a good notion of what it is to understand. In many people's perceptions, it means simply to repeat back the specifics of benefits and risks. That may be quite insufficient as a basis for understanding, because the patient may be able to repeat back information and not truly know what it is they are talking about, or even more important, be able to apply the information to their own situation.

In their discussion, the authors provide some cases where patients were found to be competent and other cases where they were found not to be competent.³¹⁵ Two examples were particularly interesting. The first concerned a 61-year old man who wanted to leave the medical ward of a hospital.³¹⁶ The patient was being evaluated for potential cancer of the lung and the physicians wanted to engage in additional medical procedures to finally establish the diagnosis. The patient demonstrated difficulties understanding the information about his condition, but he did know his name and the place. He did not know, however, why he was currently in the hospital and he indicated that he wanted to leave the hospital because it was essentially serving no purpose for him. The researchers decided that he suffered from senile dementia and that he was unable to weigh the risks and benefits of treatment because he could not understand the information presented to him or retain it. As a result he was found incompetent to refuse treatment.

The second case described a different situation. This case involved an 88-year old man who suffered from a multiplicity of diseases including Parkinson's

³¹⁴ L.R. Tancredi "The Mental Status Examination". (1987) 11 *Generations* 14.

³¹⁵ R. Weinstock, R. Copeland and A. Bagheri "Competency to Give Informed Consent for Medical Procedures". (1985) 12 *Bul. Acad. Psy. Law* 117.

³¹⁶ L.R. Tancredi "Ideology and Power: A Critique of Empirical Research in Law and Psychiatry". In B. Stanley, J. Sieber and G. Melton, *Psychology and Research Ethics* (Lincoln: University of Nebraska Press, in-press).

disease, peptic ulcer, and a history of cerebral vascular accidents.³¹⁷ This patient was found to have a large mass in the frontal area of his brain. Psychiatric consultation was requested by a surgical resident prior to surgery which was planned to remove the frontal tumour. The surgical resident was concerned that the patient may not be competent to consent to surgery. The patient did not appear to appreciate the risks of surgery, nor to demonstrate any understanding of his condition. Nonetheless, he was oriented as to person and place and even understood the situation he was currently in. He was not, however, oriented as to date. The patient stated that he would be fine following surgery, but the researchers apparently disagreed with his position. They claimed that he had no evidence to support his optimistic judgment. The patient was diagnosed as having a mild dementia which the researchers felt interfered considerably with his ability to consent to the procedure. But, in fact, what underlaid their decision was the fact that the surgery to remove the frontal lobe had a high risk. Furthermore, its benefits were somewhat questionable, especially in an individual of this patient's advanced age. Applying an earlier test which required a high threshold level of capacity in those situations where the risk is high and the benefits somewhat dubious, the authors concluded he was incompetent.

These situations pose interesting issues. In the first case the patient's rights are overridden regarding his capacity to refuse treatment. The procedure was diagnostic for the purpose of determining the presence of cancer of the lung. In addition, it was not classified as high risk, nor of questionable benefit. The researchers, however, assumed that this patient was incompetent and, because of this determination, had his right to refuse the procedure and leave the hospital denied. The ideological stance of the physician seems to fit clearly into the medical model that stresses the benefits of medical diagnosis and treatment over the risks. More significantly, the ideological stance emphasizes the benefits where the risks are not sufficient to trigger the threshold test for protecting patients, even when this threshold test would be over and beyond the individual's own preferences. The fact that a patient is unable to retain information or to "weigh" a highly value-laden notion does not mean that he is incompetent to make a decision. A patient 61 years of age, however, with a potential malignancy of the lung would be accorded the benefit of doubt regarding his sense of his own preferences. In this situation, the preference may well be to avoid a serious operative procedure or to leave the hospital and to be left alone. When such preferences are expressed by an inarticulate person they are balanced out in favour of the medical exigency and

³¹⁷ R. Weinstock, R. Copeland and A. Bagheri "Competency to Give Informed Consent for Medical Procedures", (1985) 12 *Ibid. Acad. Pop. Law* 117.

perceived appropriateness. Where this occurs, ideological notions create power imbalances between the treaters and those receiving treatment, they shape the nature of the questions asked by researchers, and thereby they determine the resolution of those questions.

The physicians and researchers in the second case took the position that the patient was incompetent to agree to surgery. The individual's preferences were relegated to second order consideration when balanced against medical exigencies. The decision regarding informed consent, for example, was a decision of assessing the medical appropriateness of the procedure which had attendant high risks and questionable benefits in an 88-year old man. Complicating this further was the fact that the patient had numerous diseases and had the presence of a large frontal mass. The surgical resident appeared to use the informed consent proceeding as a way to halt the chain of events that would lead to surgery. From the perspective of the medically appropriate decision, it would appear that given the circumstances of age, existing disability and the presence of a frontal mass, surgery should not have been conducted. In effect, therefore, what really seemed to be at issue was not whether the patient had the capacity to agree or disagree about surgery, but rather whether that surgical procedure should ever have been presented as an appropriate method for treating his condition. There was obviously sufficient ambivalence among surgeons and the surgical residents on the critical question of quality of care, so that the patient's ostensible "incompetency" to decide the issue provided an easy way out.

Another study creates similar difficulties in delineating valid from ideologically weighted data. This study involved evaluating the ability of psychiatric patients to consent to psychiatric hospitalization.¹¹⁸ Using several alternative definitions of competence, researchers tested 50 psychiatric patients shortly after admission and found that most of them demonstrated severe impairments of capacity. Fifteen questions were asked of the patients, involving such subjects as their appreciation of the nature of their condition, comprehension of the reason admission was recommended, awareness of the nature of hospitalization, ability to decide whether to cooperate with the treatment plan, ability to protect themselves in the hospital context, and awareness of their rights as outlined in materials distributed at the time of admission. A doctrine or ideology of error has been precluded from consideration by the researchers. This is demonstrated by some of the questions asked the patients.

¹¹⁸ P.S. Appelbaum and L.H. Roth "Clinical Issues in the Assessment of Competency". (1981) 128 Am. J. Psychiatry 1462.

- Do you think that you have psychiatric problems?
- Do you think you need some kind of treatment for your problems?
- Do you think that you need to be in the hospital to get that treatment?
- Why do you think the doctor you saw recommended that you come into the hospital?
- What will the medication do for you while you are in the hospital?

In discussing the results, the researchers pointed to data indicating that half of those newly admitted did not think they needed to be hospitalized for treatment. Furthermore, "only 46% could clearly acknowledge that they had psychiatric problems".³¹⁹ They concluded that this indicated that these patients "were not engaged in the rational manipulation of information that is a desirable element in any definition of competency".³²⁰ However, the framework of the questions leading to specific responses inevitably led to the conclusion of the researchers. The questions precluded an assessment of the error in the research itself. Once the questions were delineated, the study appeared consistent; but the ideological basis for the questions, though critically important in defining the questions, remained relatively hidden.³²¹

Specific responses to the questions illustrate their ideological basis. A negative response to the first three questions and an oppositional response to the last two -- attacking the doctor's judgment and denying benefit from the medication -- does not automatically serve as conclusive evidence that the patients could not engage in the "rational manipulation of information," unless one is so ideologically convicted as to conclude that only one range of responses under these circumstances evidences competence. If this position is taken, then logically, according to the researchers, patients would be given only the option to voluntarily accept recommended treatment. Should they refuse, they are judged incompetent and their rights to refuse psychiatric treatment can be consequently overridden. The study provides for no doctrine of error because there is no explicit recognition of when error occurs within the intellectual framework of the abstract concepts being examined. There are essentially no alternatives but to answer the questions

³¹⁹ *Ibid* at 1465-1467.

³²⁰ *Ibid* at 1466-1467.

³²¹ L.R. Tancredi and D.N. Weinstub "The Ideology of Epidemiological Discourse in Law and Psychiatry: Ethical Implications". In L.R. Tancredi (ed.), *Ethical Issues in Epidemiologic Research* (New Brunswick: Rutgers University Press, 1986).

to accept treatment and thereby be judged competent, or reject and thereby be judged "incompetent" to refuse -- a "catch-22" situation.

B. LIMITATIONS ON THE VALIDITY OF EMPIRICAL STUDIES - SUMMARY

A primary postulate of this discussion is that both the methodology and underlying ideology of research must be critically examined, especially the extent to which they influence the content, arrangement and interpretation of data. This discussion also emphasizes that the application of research methodology in forensic psychiatry is problematic. It must deal with broad and often ill-defined concepts such as autonomy and competency. Also, the results of such studies are increasingly influential in informing courts and legislators and in shaping many policies in the field. It is necessary to be able to recognize when a methodological error exists which produces inconsistent results and when an ideology which is indirectly exerting influence through the production of data is "false" or distorting reality because of some epistemic property or the underlying beliefs being represented. The hidden determinants of what passes for research objectives that ultimately generate data that may influence policy must be unearthed and exposed while assessing the value of studies.

A most basic truth germane to this discussion is that knowledge generally means power.¹²² Researchers who influence the way knowledge is obtained about a sequence of events, and how it is presented to decision makers, have a major advantage over others, especially patients and non-patients affected by legal decisions. Empirical studies enhance the power of the expert in society. An epidemiological study may tip the power balance in a court decision in favour of the professional over the interests of the patient. Scientific data are rarely neutral. Scientific judgments may be less value-laden than other decisions in society -- such as political decisions -- but, they are not free of values. Because of the incredible value placed in our present era on empirical results, conclusions drawn from such studies are given undue weight by decision makers.

Few means are available for those affected, such as patients, to rectify the imbalance created by scientific data which in any one situation may cause injustice to various segments of society. Ideological critiques, which are concerned with the very essence of the values of a study from its conception to its operation and interpretation, would create a more favourable balance of power between

¹²² I. Habermas *Knowledge and Human Interest* (Boston: Beacon Press, 1968).

researchers and subjects of research, or more appropriately, physicians and patients in the mental health system.³²³ Ideological as well as methodological critiques in the forensic psychiatry area would enhance patients' autonomy by diminishing the power created by the uncritical acceptance of the results and interpretation of research studies.

C. CRITERIA VERSUS INSTRUMENTS FOR TESTING CAPACITY

In examining the notion of testing for mental decision capacity, certain terms need to be defined. "Test", as used in this document, will refer generally to the implementation of a set of criteria through the application of certain instruments and procedures. The two critical components of what constitutes a test are therefore the criteria and the instruments.

Criteria refers to those capabilities and other parameters that need to be enumerated with regard to each of the forms of decisional capacity in question. For example, an important criterion for informed consent in the treatment context would be the patient's "understanding" of the information provided by the clinician regarding benefits, risks and alternative treatments. Instruments refer to the specific bio-medical or neuropsychological tools that are used to assess the individual's capabilities with respect to the specific criteria. For example, the instruments that could be used to assess whether an individual meets the example of a criterion above, include a range of neuro-psychological tests for cognition: the WAIS, and the Mental Status Examination, the Wechsler Memory Scale, are but a few.

The distinction between the specification of the criterion and its implementation is an important one in this context. Insofar as it is reasonable to expect that the evolving nature of research on neuropsychological and biomedical instruments will result in the development of improved means for assessing the relevant parameters, this report will leave the selection of such devices to the judgment of the clinical expert responsible for the assessment. The following sections summarize the present state of the art regarding the specification of criteria and test instruments, and identify some of the limitations inherent in same.

³²³ L.R. Tancredi and D.N. Weisstub "The Ideology of Epidemiological Discourse in Law and Psychiatry: Ethical Implications". In L.R. Tancredi (ed.), *Ethical Issues in Epidemiologic Research* (New Brunswick: Rutgers University Press, 1986).

D. REVIEW AND CRITIQUE OF EXISTING CRITERIA

The subject of competency as a specialized language and highlighted sub-topic of the mental health literature emerged relatively recently. The classical piece in the area, "Tests of Competency to Consent to Treatment", under the primary authorship of Loren Roth, appeared in the *American Journal of Psychiatry* in March of 1977.³²⁴ In that article, the basic contours for the determination of competency were outlined and a number of categories were set into place which have essentially dominated writing on the topic since then. One of the latest publications of note, "Assessing Patients' Capacities to Consent to Treatment", by Appelbaum and Grisso,³²⁵ represents no significant advance over the earlier categories. Classically stated, the language of competency was divided into the simple decision making fact called "evidencing a choice", a detailing of the understanding factor divided into capacity and actual understanding and references to an assessment of outcome based upon a reasonableness standard and an appraisal of the rationality of the decision making process.

A critical survey of the aforementioned categories readily reveals that the phenomenon of communicating a choice, without further detail, refers to a low threshold of statement-giving which is either meaningless without further investigation, or put in another way, trivial. Once capacity has been raised as an issue, the real questions are related to understanding and judgement. With respect to understanding, it should be seen that the distinction between capacity to understand and actual understanding does not accomplish more than logic-chopping if we accept the fact that no assessor of the competency question will look at capacity in isolation from the functional context at hand, namely whether the patient having undergone an information transaction can make the necessary connection to his or her own situation in order to ensure that the person is truly capable in the circumstances. To submit that the distinction must be drawn between competency as a matter of capacity and actual understanding as the informed consent issue is to press for a distinction which, although logically correct in the sense that capacity is a pre-condition for informed consent, is on the other hand to fail to accept the reality that without an assessment of information applied to the situation, the person's capacity assessment becomes abstracted and trivialized at the same time. It is difficult to understand how understanding information can

³²⁴ L.H. Roth, A. Meisel and C.W. Lidz "Tests of Competency to Consent to Treatment". (1977) 134 *American Journal of Psychiatry* 279.

³²⁵ (1968) 319:25 *New England Journal of Medicine* 1635.

be separated out from the process of responding to and using information rationally. As one author has rightly stated:³²⁶

With regard to information and its relationship to competence, I am suggesting a reversal of the traditional roles. Traditionally, it was thought that the ascertainment of competence was an issue which needed to be decided prior to the transmittal of information. To the contrary, I believe that information is prior to competence, in that a competent decision includes, but extends beyond, the requirement that the person involved be able to allow the informing process to enter into his decision making in a substantial way. He must be capable of utilizing the information provided in formulating his reasons.

Although authors continue to argue that competency, and criteria for it, must be distinguished from standards or tests for informed consent, it is really hard to get any meaning out of capacity without relating rationality or some variation of it to an understanding criterion. In saying that, it may well be that functionally and theoretically the best we can achieve is to answer the consent question by testing the waters of "information analysis" through a capacity determination. If the capacity issue is dealt with meaningfully, then there should be a clear road to answering the informed consent question conclusively once certain legal criteria are fulfilled, such as voluntariness and the specific amount of information that is legally required by law applied to the medical intervention in question. From the rationality standpoint, capacity should be required as the key playing card in the decision making process of exchanging information between a treater and the patient.

Much of the conceptual literature on competency moves between the language of understanding and appreciation. Appreciation refers to the additional conceptual baggage of dealing with consequences. Appreciation at its worst can represent a tyranny of experts such that a patient's way of looking at the consequences of a particular decision will be lined up against the best or better judgement criterion consistent with sound professional practice. That, in effect, would be to make a mockery out of patient autonomy and the values which we uphold in our current legal system, given our respect for personhood. Appreciation, therefore, has been taken away from reasonable outcome analysis. Although still connected in some way to an appreciation of consequences, at least in Appelbaum's most recent analysis, there is an attempt to say that the reasonableness of the decision will be separated out from the appreciation of likely outcomes. "Testing patients' ability to appreciate a situation requires eliciting their conceptions of their illness, their need for treatment, the likely outcomes, and the motives of those involved." In the same section, entitled "Appreciating the

³²⁶ B. Freedman "Competence, Marginal and Otherwise: Concepts and Ethics". (1961) 4 *International Journal of Law and Psychiatry* 53 at 65.

Situation and Its Consequences", Appelbaum asserts "A patient's realistic evaluation of these factors should be distinguished from the reasonableness of the decisions the patient makes".³²⁷ This notion suggests a distinction between realism and reasonableness, which presumably solves the riddle of the concentration of a proper description of reality between treater and patient. Alas, one can assume in many cases that the dispute about what is reality is interconnected to the reasonableness of the decision. To make the distinction as Appelbaum does, does not solve the problem unless we want to restrict the matter of appreciation to examples of hallucination or delusions. There are many situations which pertain to the issue of judgment which force us to appraise the subtle connectors between reality claims and the perceived reasonableness or unreasonableness of denying patients.

The crux of the matter of judgment falls down on the question of what it means to assess the capacity of people to reason through their decisions, including those related to treatment. One can talk about rationality as logic, the ability to manipulate information, to give recognizable reasons, or to show in one's life's practices a presumptive pattern of ordered or sensible behaviour. Figuring out what is the justified medical, legal, or philosophical claim on the rationality option is the key to the concept of competency and/or decision making capacity. Where one sets the threshold will make the difference in how one views one's justification for setting the threshold in one spot as opposed to another, and tells us a great deal about the universes which surround the discourses of professions such as law or medicine and one's philosophical values, for example, which structure a balance between paternalism and autonomy.

It is interesting to note that in Appelbaum's latest article, which follows an elaborate commentary and revision of the original Roth outline, there still remains an ambiguity about what constitutes a justified threshold for patient coherence. Appelbaum states:³²⁸

It is the process that is at issue here. ... Rational manipulation involves the ability to reach conclusions that are logically consistent with the starting premises. This requires both weighing the risks and benefits of a single option and usually more complex process of weighing multiple options simultaneously, in a way that reflects the weights previously assigned to them.

Appelbaum goes on to say that after the patient's chain of reasoning is examined, we can observe that "the outcomes should generally reflect the weighing

³²⁷ (1988) 319:25 *New England Journal of Medicine* 1635 at 1636.

³²⁸ *Ibid.*

of these factors".³²⁹ Is this a neutral scientific process of investigation separated logically and functionally from an outcome analysis? Do we have a precise notion of what is entailed in a sympathetic appraisal of reasonableness? Do we have a clear way of distinguishing the rational manipulation of information from appreciating the situation and its consequences? In our view, we do not. In fact there remains, after a steady honing down of categories, a persistent set of discomforts about the analytical integrity of categories which are being utilized to assess competency, and which were apparently meant to resolve the annoying difficulty of separating outcome analysis from process. This central problem has not been solved, nor have the criteria for rationality ever been clearly defended in the Appelbaum trajectory of articles. In fact, Appelbaum hedges in his selection on logical criteria for rational decision making by deferring in his final sentence to the work of Benjamin Freedman "Competence, Marginal and Otherwise: Concepts and Ethics".³³⁰ Appelbaum writes "it has been suggested that asking patients to produce 'recognizable reasons' for their choices may be an adequate proxy for a more detailed investigation".³³¹

Although we could presume that Appelbaum would defend this alleged ambiguity between the process of giving logical reasons and accepting recognizable reasons as a flexible process which the doctor could employ in favour of patients, in fact Freedman's article implicitly represented an attack on physician or other professional forms of discretionary power. As Freedman commented on the issue of rational reasons:³³²

It needs to be noticed, however, that a considerable potential for abuse lurks in such a criterion. People, however competent, are not always prepared to give reasons for their choices. We should also recall that rationality can be demonstrated in the way in which a person orders his life, not merely in the verbal justifications he gives for his behaviour.

Almost concurrent with the publication of Freedman's criticisms, Loren Roth in a 1982 article entitled "Competency to Consent to or Refuse Treatment" said:³³³

Freedman has recently formulated what he believes is a more value-free approach to assessing patient competency: the patient's reason for consent or refusal must be recognizable, if not rational, in order

³²⁹ Ibid.

³³⁰ Noted Supra.

³³¹ (1988) 319:25 New England Journal of Medicine 1635 at 1636.

³³² (1981) 4 International Journal of Law and Psychiatry 53 at 65.

³³³ L.H. Roth "Competency to Consent to or Refuse Treatment". (1982) Part IV *Psychiatry* 1982 350 at 355.

to be competent (Freedman, in Press). Despite the desirability of such an apparently neutral standard, there remains considerable doubt as to how one would implement such a value-free approach to competency.

Apparently Roth thought that Freedman's flexible and homespun standard of recognizability was a challenge to the value laden world of medical ideology, which if not represented by Roth as a value-free science, was at least being protected as the centre point of professional judgement where one could justifiably medicalize rationality without the assistance of philosophers. This quarrel between a common sense understanding of practical reasoning and the medical determination of what constitutes rational discourse lies at the root of our current discussions about competency and how we should go about justifying our decisions in respect of it. Appelbaum's contribution of 1988 escapes from dealing with the tension point identified here with regard to medical judgements about judgements. If it is the case that the criteria for competency are admittedly as both Roth and Appelbaum have accepted -- a matter of legal and not medical determination -- at the end of the day, we must figure out what the territory is between medical and legal criteria and medical and legal processes of evaluation. In fact, we must sort out the extent to which the evaluative process serves to clarify or to obfuscate criteria such as appreciation, analysis of outcomes, and the ability to manoeuvre information rationally.

E. REVIEW AND CRITIQUE OF TEST INSTRUMENTS

1. Diagnoses and the Problem of Certainty

Before reviewing the more important biomedical technologies and neuropsychological instruments, some conceptual issues relevant to the role of diagnostic technologies generally will be discussed. Diagnostic technologies are evaluated based on their medical purpose and how their findings relate to what is actually occurring in the patient or client. Cochrane³³⁴ points out that clinicians frequently argue that the benefits of diagnostic tests rest on their ability to ferret out abnormalities and their high correlation with findings on a pathological examination of tissues of the body -- at the time of an operation or shortly after, such as post-mortem. Cochrane contends that the welfare of the patient as justifying diagnostic processes is ancillary to these more "scientific" objectives. But underlying this claim of proponents of diagnostic tests are serious questions about

³³⁴ See A.L. Cochrane *Effectiveness and Efficiency: Random Reflections on Health Services* (London: The Nuffield Provincial Hospital Trust at 35, 1971).

what it is that many diagnostic procedures are actually doing and how effectively.³³⁵ Since such procedures are used mostly in medical care, the literature on statistical relevance of diagnostic methods is concerned with medicine. However, the issues raised are relevant to nearly all tests used to differentiate humans in a wide variety of settings – schools, workplace, courts etc. In medicine, the results of many tests do not necessarily correlate to as high a degree with findings on pathological examinations. In a recent study, researchers examining one university teaching hospital found that 10 per cent of the autopsies disclosed the presence of a major disease that went unrecognized clinically and might have responded to treatment, and another 12 per cent established previously undocumented major clinical diagnoses for which early treatment would probably have made little or no appreciable difference for the patient.³³⁶ A subsequent study of autopsies and death certificates showed that circulatory disorders, respiratory disorders and many ill-defined diseases are frequently over-diagnosed and other conditions such as gastrointestinal disorders and traumatic events frequently underdiagnosed in death certificates. These inaccuracies are due in part to reliance on diagnostic procedures and suggest that such procedures may produce inaccurate results more frequently than one would expect.³³⁷

How a diagnostic technology functions in detecting abnormality is complicated further by scientific underpinnings that are not value-free. Values affect the interpretation of diagnostic signals. A series of questions should reveal this relationship. First, does the diagnostic test do what it claims it does? For example, if it is an imaging technology, does it really take a picture or image of a structure of the body and is it able to distinguish the image from similar images to determine what is "normal" and what is "abnormal"? This requires that the technology reflect precisely either the structure or the functional differences that it alleges exist in the body tissue, or brain being examined. Second, does the test produce a consistent and easily detectable indicator of the condition believed responsible for the incapacity (cluster of signs, symptoms, etc.) that it claims to identify? Is the test consistent and regular in the production of the image, whether structural or functional, so that the indicator or marker of abnormality relates to the disease condition? The image may be consistent, in that it discloses an

³³⁵ See S.J. Adelstein "Pitfalls and Biases in Evaluating Diagnostic Technologies". In B.J. McNeil and E.G. Cravinho (eds.), *Critical Issues in Medical Technology* (Boston: Auburn House at 67, 1982).

³³⁶ See J. Goldman, R. Sayson, S. Robbins, L.H. Cohn *et al* "The Value of the Autopsy in Three Medical Eras". (1983) 308 *New England Journal of Medicine* 1000.

³³⁷ See T. Kircher, J. Nelson and H. Burdo "The Autopsy as a Measure of Accuracy of the Death Certificate". (1985) 313 *New England Journal of Medicine* 1263.

abnormality in the structure or function of the section of the body that is being examined, but these abnormalities may not always correlate with physical signs and symptoms such as "incompetency" in all individuals. This lack of correlation is particularly important if a specific diagnostic technology is to be used for screening where the sequence is reversed, that is where the purpose is first to detect the abnormalities of images in a large population and on the basis of that deduce statistical levels of the condition. Consistency requires that the marker of abnormality fit with what is subjectively experienced by individuals who have a condition or disease. Therefore, the underlying value of consistency is that the presence of abnormality derived from the imaging technology directly relates to the presence of abnormality in the condition of the individual being examined.

The third question involving values asks whether the diagnostic technology actually expands the scope of what was originally conceptualized as the condition affecting the capacity that is being examined. The diagnostic test results may indicate the presence of disease even though in any one instance there may not be symptomatic evidence to support this conclusion. This issue is similar to the second question discussed above, except that it is concerned with the significance that may be attributed to the marker when one is dealing with vague criteria, such as in diseases that are of a behavioral or psychological nature. Increasingly, images of the brain are being associated with pathological changes of neural tissue and behavioral manifestations.

The linkage between the indicator (e.g., image) and the outward manifestation of behaviour may involve one of the following: first, in any one instance there may not appear to be a correlation between the marker and what it is supposed to be indicating; or, second, and more problematic, the behaviour of the individual with the abnormal reading may be interpreted to support the indicator when there may be little basis for that interpretation. The tendency may be compelling to view the diagnostic technology as capable of objective truth, ignoring that the marker is the product of a statistical determination of what is abnormal. It is easy to lose sight of the variations among those being assessed for capacity and to take the results as unquestioned evidence of a disease or precursors to a serious condition. The problem is most troublesome when a behavioral or psychological condition such as an incapacity is the subject of diagnosis and there is no physical manifestation to provide an objective basis for the disease. When this occurs, the diagnostic technology's characterization assumes "objectivity" like a physical manifestation and the presence or absence of behavioral changes become inconsequential to the diagnosis.

Diagnostic technologies are used essentially to determine significance of a physical or psycho-behavioral manifestation and because of biological "objectivity" take on significant weight in determining what is normal from what is abnormal. Where one is differentiating between normal and abnormal involving psychological or behavioral problems, even with a seemingly objective test like electroencephalogram (EEG) which measures brain waves, the distinctions are less clear cut. An individual may demonstrate what we would consider abnormal behaviour patterns and show minimal changes in an EEG.³³⁸ Some early work done by Rothschild and Sharpe correlated the amount of brain tissue damaged with the degree of behavioral aberration and found that there did not seem to be much correlation between the two.³³⁹ Some patients who suffered severe behavioral disorders on physical examination of the brain were shown to have minimal organic brain changes. In contrast, massive brain alterations were sometimes seen in patients with mild or no behavioral disorders. Even with the use of so-called hard diagnostic tests like X-ray, some have argued that the effectiveness of X-ray as a diagnostic tool for a wide range of pathologies is poor when contrasted with the effectiveness of biopsies.³⁴⁰

The importance of examining the validity of diagnostic tests can not be over emphasized. Test results take on major significance in institutional decision making because they present themselves as objective. The more complex the technology that is used for diagnosis, the more it enters into the health care system and other contexts with an aura of accuracy and infallibility. This alone makes it essential that these technologies undergo assessment, focused on their effectiveness for accomplishing what they claim they accomplish. To achieve this technology assessment involves several concepts that deal significantly with accuracy and precision.³⁴¹ The first is the notion of "efficacy" which refers to the extent to which a medical technology is beneficial to a defined population when it is applied for a medical problem (i.e., capacity determination) under the most ideal conditions. An example is the use of Positron Emission Tomography (PET) for diagnosing epilepsy,

³³⁸ See L.N. Robins "Epidemiology: Reflections on Testing the Validity of Psychiatric Interviews". (1985) 42 Archives of General Psychiatry 918.

³³⁹ See D. Rothschild "Senile Psychosis and Psychosis with Arterial Sclerosis". In O.J. Kaplan (ed.), *Medical Disorders in Later Life* (Stanford: Stanford University Press, 1956).

³⁴⁰ See L.N. Robins "Epidemiology: Reflections on Testing the Validity of Psychiatric Interviews". (1985) 42 Archives of General Psychiatry 918.

³⁴¹ See H.D. Banta and J.R. Sanes "Assessing the Social Impacts of Medical Technologies". (1978) 3 J. Com. Health 245.

stroke and tumours in a highly sophisticated center like the Brookhaven National Laboratories.³⁴² The "effectiveness" of that technology, in contrast, is determined by whether it accomplishes what it claims to when it is used in the real world in the community. Many factors, such as the competency of those who are actually using the technology and those who are engaging in the interpretation of the results, influence the accuracy and effectiveness of a technology in practice.

In establishing efficacy or effectiveness, it is important to assess the accuracy of the test as it is employed with a large population.³⁴³ When this is done, concepts such as "sensitivity" and "specificity" become particularly important. The sensitivity of the test would mean its ability to separate what is abnormal from what is normal. Specificity would mean its ability to identify specific conditions. In assessing both specificity and sensitivity one would be concerned with the true positive and true negative rates of the diagnostic tests. True positive refers to the probability that the test will be positive in the presence of the pathology that it is detecting. True negative means the probability that in the absence of a particular pathology the test will be negative. In contrast to these terms are concepts such as false positive where the test identifies a particular problem that does not exist, and false negative, where the test fails to identify a condition that does exist.

In the context of a screening program it is often more important that a screening device have a low false negative than that it have a low false positive rate.³⁴⁴ If the screening device picks up a condition that does not exist, other diagnostic tests that will be used later will be able to relatively easily factor out those false positive determinations. But in the case of false negatives, where the test does not pick up a condition that does exist, the individual may be lost to rehabilitation at a critical moment in the evolution of his or her disease process that leads to incapacity. For example, a patient with a very early disorder of metabolism that goes undetected may have significant changes in mental status before it is properly diagnosed. On the other hand, from a social perspective, all

³⁴² See N.D. Volkow and L.R. Tancredi "Positron Emission Tomography: A Technology Assessment". (1986) 2 *International Journal of Technology Assessment and Health Care* 577.

³⁴³ See P.L. Sackett and M. Gent "Controversy in Counting and Attributing Events in Clinical Trials". (1979) 301 *New England Journal of Medicine* 1410 and H.S. Sacks, J. Berrier, D. Reitman, V.A. Ancona-Berk and T.C. Chalmers "Meta-Analysis of Randomized Controlled Trials". (1987) 316 *New England Journal of Medicine* 450 for a discussion of problems in assessments.

³⁴⁴ See D. Nelkin and L.R. Tancredi *Dangerous Diagnostics: the Social Power of Biological Information* (New York: Basic Books, 1989).

of these technologies have both medical and social purposes.³⁴⁵ The false positives may create serious problems. For illustration, take a technology that may be used in the school system, such as a diagnostic test for disclosing relative incompetency for daily decisions. The false positives may experience distress because they have been improperly labelled as incapable, and it may take considerable time before the inaccuracy is discovered.

2. Biomedical Technologies

The following discussion will examine the biomedical basis of diagnosis and the new diagnostic technologies for assessing behaviour.³⁴⁶ Many of these techniques are still in the experimental state, but they highlight the conceptual problems of scientific accuracy in determining capacity in a variety of circumstances. This review is relevant to the determination of capacity as such determinations rely on medical and psychological evaluations. These evaluations are similar to the process of diagnosing physical pathology. They rely on certain techniques for revealing abnormality. Many of the methods used in diagnosing psychiatric problems are applicable to the issue of capacity. Hence this discussion will address the process of diagnosis, its strengths and weaknesses, the validity of interpretation of test results and finally the emerging technologies and their scientific relevance for supporting clinical evaluations of capacity.

There is a long history of testing as a process for control, exclusion and manipulation, or more explicitly, as an empowering of authority in certain social institutions. Capacity determinations rely on imprecise clinical and psychological tests. As a result, they must be used very sparingly in efforts to curtail individual rights. These determinations have infiltrated all aspects of life. Many social analysts have addressed this problem over the past twenty years, and expressed concern particularly with the impact of competency testing on a wide range of social decisions in various settings.

Since the mid-60s, the focus of review has been on commitment of patients in mental institutions and the concomitant assumption of incompetency. The merger of involuntary commitment and competency clearly enhances the power of

³⁴⁵ See D.N. Eddy "Pitfalls and Biases in Evaluating Screening Technologies". In B.J. McNeil and E.G. Cravalho (eds.), *Critical Issues in Medical Technology* (Boston: Auburn House at 53, 1982).

³⁴⁶ We would like to acknowledge the contribution of the recent publication of D. Nelkin and L. Tancredi, *Dangerous Diagnostics: The Social Power of Biological Information* (New York: Basic Books, 1989) to this discussion.

the psychiatrist in mental health care. Laws throughout the United States and Canada underwent revision during the late 60s and 70s to reflect a more enlightened awareness that the two notions, justifications for commitment and incompetency, do not necessarily coincide. The purposes of both differ in many respects, sufficiently so that different legal criteria have been crafted for determining when patients should be hospitalized and when they should be considered incapable.

There has been an explosion in the development of technologies for diagnostic purposes since the 60s. Technologies exist now that run the gamut of human biophysiology, from subtle changes in enzyme reactions to complex biomedical mechanisms that can only be detected through sophisticated imaging technologies. With the evolution of bidiagnostic technologies, two themes seem to have dominated. First, over the past several decades diagnostic technologies have pierced the external frame of the body to become involved with deep internal bodily functions. Second, a belief exists in both increasing accuracy and precision from greater refinement in instruments that enhance the basic diagnostic process, and in the benefits of technologies that are radically different from their precursors.

The development of the X-ray in the early part of the 20th century began not only to shift the focus of diagnostic instruments to more direct visualization of internal structures but also facilitated the application of physics, electronics, radiation and complex mechanical devices for establishing more fully what is actually occurring inside the body. In recent years, imaging technologies have mushroomed to include sophisticated technologies such as the computer assisted tomography (CT Scan), computerized EEGs (CEEGS), Superconducting Quantum Interference Devices (SQUIDS), Brain Electrical Activity Mapping (BEAM), Positron Emission Tomography (PET), Single Photon Emission Tomography (SPECT), and Magnetic Resonance Imaging (MRI) to name several of the more important technologies. These new technologies not only allow for visualization of internal structures of the body, but with PET in particular, also provide understanding of the functional capacities and differences among internal organs, especially the brain.

At the same time that these developments have occurred, there has also been a move to understand deeper internal cellular differences among people through genetic testing. Such tests assess the basic biological substrate, genes, from which physical, emotional and psychological characteristics emerge. Genetic evaluation is in some respects the most internal of the diagnostic processes because it gets at the subcellular structures which determine to a large extent the individual

organism's potentiality for a relatively disease-free existence during its life span. In some respects genetic testing and evaluation place more emphasis on prediction than do imaging technologies, though all of these diagnostic processes contain predictive capacities as well as the ability to determine at any one point in time the nature of the body as a biophysiological entity.

In some respects, the shift of focus from external signs and symptoms of disease to detection more directly of internal functions, has been accompanied by greater accuracy because the process of interpretation in this case relies less on inference through external manifestation and more on the direct detection of what may be occurring internally. The attempt to move away as much as possible from inferential diagnosis, i.e., the detection of markers that are secondarily or distantly related to the underlying condition, towards more direct assessment of the organs that are abnormal or of genetic structures that are damaged and thereby related to serious diseases, represents the primary struggle or tension that has occurred in the history of diagnostic technologies. On close scrutiny, however, even direct assessment of genetic material, through complex DNA technology, may not always provide an acceptable level of accuracy for establishing the presence of a genetic disorder. Other factors not elucidated by the detection of a marker alone may interfere with the transmission of traits to prevent the highest degree of precision for detecting the disease or condition under investigation.

The effect of new technologies on diagnostic accuracy is particularly relevant to their applicability in determining capacity. There is an underlying belief that refined techniques have increased the certainty of detecting abnormal conditions. This ideology is unfortunately intertwined with a basic extolling of things scientific, an extolling that frequently precludes critical examination of the ends ostensibly achieved by secondary technologies. Some sub-issues become particularly relevant with regards to the application of technologies in establishing capacity. The most important of these are: 1) What kinds of technologies have emerged from recent biological developments and what types are likely to appear in the future? 2) How do these technologies function, or how are they likely to function in the identification of incapacity? and, 3) When do these technologies serve social rather than medical purposes?

a. Genetics and Competency

Over the past decade, the two areas of major breakthrough are genetics and neurophysiology. Regarding the first, there is a strong indication that in the very

near future the human genome will have been totally mapped,³⁴⁷ and markers will be identified to allow for the prenatal and pre-symptomatic detection of nearly all known genetic diseases now numbering over 3,000.³⁴⁸ Since the late 70s the methodology of recombinant DNA has evolved to become a sophisticated technique that allows for sequencing of base pairs in a segment of an individual's DNA. With the use of enzymes such as restrictive endonucleases, of which over 200 have been identified, it is possible to effectively cleave human DNA into thousands of fragments.³⁴⁹ Each endonuclease cuts a specific region in a short sequence of nucleotides. As there are many base sequences recurring in a genome, many endonuclease fragments are produced. These fragments may be incorporated into DNA and replicated many times in bacteria.³⁵⁰ This is one method for producing a DNA probe. Once the fragments are produced, they can be radioactively labelled, allowing identification of complementary sequences that will bind to it. This can be a useful process for identifying fragments on sections of DNA as well as locating sequences on chromosomes. Through pulsed field gradient electrophoresis DNA fragments are separated out, including the DNA probe and its complementary sequence. Photographic emulsion provides the means for visualizing the DNA probes that are radioactively labelled.

In addition to these processes, the identification of restriction fragment length polymorphisms (RFLPS) has been important for gene analysis. These are substitutions of nucleotides along a DNA strand at frequent intervals and occur aberrantly in the population. Some of these polymorphisms are located at sites of action of restrictive endonucleases. The sites are likely to be inherited so that the combination of RLPs and family analysis of various genetic traits may create markers on a gene that may reveal abnormalities. At least 350 such markers are now known in the human genome and many more will soon be discovered. The presence of markers increases the accuracy of determining genetic abnormality.³⁵¹ Where the marker is near the gene in question and a DNA probe is done of that

³⁴⁷ See R. Cook-Degan "Introduction and Overview". (August 1987) Office of Technology Assessment Report, (OTA Report).

³⁴⁸ See V.A. McKusick *Mendelian Inheritance in Man*, (7th ed.), (Baltimore: Johns Hopkins University Press, 1986).

³⁴⁹ See N.A. Holtzman *Proceed With Caution: Predicting Genetic Risks in the Recombinant DNA Era* (Baltimore: Johns Hopkins University Press, 1989) at 9-13.

³⁵⁰ See N.A. Holtzman *Proceed With Caution: Predicting Genetic Risks in the Recombinant DNA Era* (Baltimore: Johns Hopkins University Press, 1989) at 13-20.

³⁵¹ See R. Johnson "DNA Probes Limited in Medical Diagnoses". (June 1987) Genetic Engineering News 23.

marker in an unknown person and found to be present, it is highly likely that the individual will have the abnormal gene. A DNA probe of a marker is not 100 per cent accurate; there will be some error in predicting, depending on the distance between the marker and the gene. Where flanking markers have been identified, that is, markers on each side of the suspected gene, a DNA probe in an unknown person locates the markers, the level of certainty will likely be higher than 99 per cent, but still not 100 per cent because of the remote possibility of double crossing over.³⁵² On the other hand, if the DNA probe is directed to an intragenic marker, that is, a marker that is actually within the sequence of the gene itself, then there is 100 per cent certainty that an individual who shows that marker has that particular genetic sequence.³⁵³

DNA probes have not yet been developed for most genetic conditions, and certainly not to the point of being used as screening devices (except for a few conditions such as muscular dystrophy and Huntington's disease). However, such probes will exist in the near future. When contrasted with more inferential measures, such as determining enzyme intensities based on the presence of end products of metabolism, the DNA probe will be much more accurate, in some cases approaching 100 per cent certainty in identifying the abnormal gene. It is likely, however, that some genetic conditions also require the action of modifier genes or non-genetic factors for the trait to be realized, in which case localizing the specific gene would not be sufficient to rule out false-positives. In the future, when genetic mapping is complete and nearly 100 per cent of the human genome has been sequenced, DNA probes will be very useful and expedient for identifying genetic diseases and even genetic susceptibilities. The importance of this capability for capacity determination is that some have estimated that 40 per cent of the body's DNA involves the brain directly.³⁵⁴ Combine our knowledge about genetics with neuroscience advances and the future might see the profiling of individuals, perhaps at birth, in terms of potential growth of mental capacities, and the likelihood of serious diseases affecting capacity. One could speculate that genetic profiles will be possible, and will include probabilities of specific conditions -- physical, mental, functional, etc. -- some of which will be inevitably associated with conditions or diseases rendering the individual incapable. In some cases, the genetics might

³⁵² See U.S. Congress, Office of Technology Assessment, *Mapping Our Genes* (Washington D.C.: USGPO, 1988), (Referred to as OTA Report) and N.A. Holtzman *Proceed With Caution: Predicting Genetic Risks in the Recombinant DNA Era* (Baltimore: Johns Hopkins University Press, 1989).

³⁵³ See U.S. Congress, Office of Technology Assessment, *Mapping Our Genes* (Washington D.C.: USGPO, 1988), (Referred to as OTA Report).

³⁵⁴ See Nelkin & Tancredi, 1989, *Supra*.

reveal retarded development with the expectation that the individual may never reach certain levels of capacity. Genetic information, combined with the findings of neuroscience technologies that reveal the individual's biological physiology, can cover both the individual's condition at the time of the test and prediction of the course of his mental status, i.e., genetic prediction instantiated with the biology of a particular moment in the person's life. This technology would be a powerful tool for differentiation and exclusion.

b. Neuroscience Technologies and Competency

The second area where major biological breakthroughs have occurred is neurophysiology. Research in this field has progressed at a fast rate and has resulted in important changes in our understanding of how the brain functions. It was not long ago that the brain was conceptualized as a network of electric wires. It was believed that stimuli from the outside world entered the senses and were conducted over intersecting nerves to various sites in the cerebral cortex. Although this notion has not been disproved, it has been superseded by a more fashionable view of the brain, that of analogizing the brain to the computer. The brain tissue itself is viewed as "hardware" and the software is the underlying program that generates ideas and makes associations of images, sensations and thoughts. A third and more fitting metaphor of the brain given current research, is that of a chemical factory that produces many biochemicals which act on specific regions of the brain and outside the central nervous system. Research has focused largely on neuro-substrates of brain function and especially on how the various neurotransmitter systems which have already been identified actually operate at the cellular and regional brain level.

Several biochemical transmitter systems have been discovered and examined to determine how they affect specific brain functions. The most prominent of these involves the chemical, acetylcholine, and is often referred to as the cholinergic neurotransmitter system.³⁵⁵ A second prominent system is the indoleamine neurotransmitter system which involves chemicals such as norepinephrine, dopamine and serotonin. These biogenic amines are located particularly in the sympathetic innervation of peripheral organs and smooth muscles, and in pathways of the limbic system that are concerned with generating and controlling emotional states or moods. Although many neurotransmitters have been identified, three other systems are particularly important: first, the epinephrine neurotransmitter system which

³⁵⁵ See J.R. Cooper, S.E. Bloom and R.H. Ross *The Biochemical Basis of Neuropsychopharmacology*, (4th ed.), (New York: Oxford University Press, 1982).

seems to be involved with vasomotor and respiratory control, thermoregulation, regulation of food and water intake, and control of oxytocin and pituitary secretions. Second is the amino acid neurotransmitter system, of which five amino acids have thus far been identified. Two of them, glutamate and aspartate, serve excitatory roles in the central nervous system. GABA and glycine are involved with inhibitory actions, and finally taurine is believed to have inhibitory properties, but its actual role has not been determined.³⁵⁶ The third system involves neuropeptides which includes such chemicals as vasopressin and oxytocin (endocrinological functions within and without nervous system), opiate like substances such as enkephalins and endorphins which function in a variety of mechanisms including those involved with pain.

Research has also been conducted on the relationship of these chemicals and the movement disorders, psychological states in human behaviour. Focus of interest has been on the impact of serotonin on behaviour such as sleep and various forms of movement, and on the role of acetylcholine on behaviour such as tremors, circling behaviour and arousal. The biogenic amines are thought to have an especially important role in the development of mental disorders. The next twenty years will likely bring about expansion in the number of biochemicals that are identified in the brain and greater understanding of the link between various neurotransmitter systems and human behaviour as well as the identification of where receptors are located in the brain for biochemicals that are produced by the body (endogenous) as well as exogenous chemicals that appear to affect body and brain function.³⁵⁷

Positron Emission Tomography (PET) is perhaps the best imaging technology available for understanding the impact of various chemicals, internal as well as external, on brain function. Other imaging technologies are useful for understanding brain function, but in far more limited ways. Computer Assisted Tomography (CT Scans) is used to image structures of the body from many angles. Computerized Electroencephalography (CEEGs) involves computer control of a traditional EEG. This capacity enhances specificity in locating abnormal brain waves. Brain Electrical Activity Mapping (BEAM) is another variation on the EEG. It involves the use of the computer to produce images of the brain that provides comparisons with the electrical activity of a healthy, normal individual. Superconducting Quantum Interference Devices (SQUID) measure magnetic fields

³⁵⁶ See H.F. Bradford *Chemical Neuro-Biology* (New York: Freeman & Co., 1986).

³⁵⁷ See H.F. Bradford *Chemical Neuro-Biology* (New York: Freeman & Co., 1986).

that surround the brain. In this way, the device essentially visualizes what parts of the brain are active under certain conditions. SQUID is capable of detecting how the brain functions and computers create a three-dimensional image from the input of neuromagnetic sensors. Magnetic Resonance Imaging (MRI) in contrast involves the use of powerful electromagnets to detect signals from human tissue. These signals are translated by a computer into an image that allows for the detection of structural abnormalities such as tumours or congenital deviations. There are new imaging technologies such as the synchrotron (it relies on electron beams accelerated to high energy) which should in time allow for highly focused study of biological function. However, these new developments are still very experimental.

Because of its ability to visualize chemical activity and function, PET is currently the main imaging device for conducting *in vivo* biochemical studies of the brain with the use of tracers. Single Photon Emission Tomography (SPECT) works similarly to PET in detecting systemically administered radionuclides; however, it is not nearly as sensitive for detecting radiopharmaceuticals. This means that less radioactive material needs to be given for a PET study and the image that is obtained from SPECT does not have the same clarity of spatial and contrast resolution.

PET is a relatively new imaging technology which functions in a way different than other imaging technologies such as CT Scans, X-ray or NMR.³⁵⁸ PET involves the injecting of a radioactive material into the body of the individual being examined. This radioactive material decays by freeing a positron which collides with an electron, thereby producing two photons that travel in opposite directions.³⁵⁹ The camera, which is part of the PET, acts as a scanner to record what has occurred when the two photons simultaneously reach two pairs of detectors that are arranged opposite each other in the camera. These radioactive detectors act something like a Geiger counter to record the activity level in various positions of the biological tissue being examined.

A variety of positron emitter compounds can be injected into a subject to measure certain features of physiological and biochemical processes. For example, if we are interested in investigating the brain, we might want to study glucose

³⁵⁸ See N.D. Volkow and L.R. Tancredi "Positron Emission Tomography: A Technology Assessment". (1986) 2 International Journal of Technology Assessment and Health Care 577.

³⁵⁹ T.F. Budinger, G.T. Gullberg and R.H. Huesman "Emission Computed Tomography". In G. Herman (ed.), (1979) 32 Topics in Applied Physics Image Reconstruction From Projections; Implementation and Application at 147.

metabolism. In that case we would inject an analog of glucose (fluorodeoxyglucose) and assess regional metabolic activity and study what parts of the brain are functioning during various brain activities.³⁶⁰ PET is the only available imaging technique at the present time that can monitor basic physiological biochemical processes of various body tissues, most particularly the brain and the heart, in a non-invasive way.

Exploring what happens if an individual is given a positron emitter compound to study which part of the brain is activated while the individual is listening to a Bach organ fugue, for example, demonstrates how PET functions, and the stages of interpretation that affect accuracy. The PET camera records the radioactivity of the brain during the stimulation and feeds this information into a computer which essentially creates a picture involving an array of colours from white to green that correlate with different intensities of function. At this first level of examination of the certainty of scientific relationship, PET produces a picture through the mediation of a computer recording radioactivity as reflective of biochemical and biophysiological functioning. This first level of analysis involves whether the picture reflects what is ostensibly occurring in the brain.

As a result of the examination of pictures of a number of individuals experiencing the same sensation after being injected by the same positron emitter compound, certain images will be designated as indicators of abnormality. The second level analysis examines whether the indicator of an abnormality which has been produced through a statistical differentiation of normality and abnormality relates to the disease or pathological condition that it claims it relates to. The presence of the indicator may be related directly, indirectly or accidentally to the disease or pathology being evaluated. Even if it is related directly, it may prove to be a poor explanation of what is occurring in the brain and the reasons for those occurrences. Essentially, at this level of analysis, the issue is whether the indicator of abnormality (a PET image) is related to the condition (e.g., incapacity or condition X) and in what way this occurs. In order to assess this, the statistical reliability of the presence of the abnormal functional image with the condition X that represents a cluster of behavioral aberrations would have to be examined. Another level of potential uncertainty, therefore, is introduced into the problem of correlating a PET image with a particular condition of incapacity.

³⁶⁰ R.O. George and N.H. Wagner Jr. "Ten Years of Brain Tumor Scanning at Johns Hopkins: 1962-1972". In H.J. DeBlank and J.A. Sorenson (eds.), *Non-Invasive Brain Imaging* (New York: Society of Nuclear Medicine at 3, 1975).

There is a third level of potential problems with the certainty of relationship where the PET image actually begins to replace the clinical evaluation for determining whether the disorder is present. This problem would arise mostly if PET were used for screening where the presence of an image similar to that seen as abnormal in those listening to the fugue becomes a substitute for the clinical assessment of incapacity. The relationship between the image and the incapacity that characterizes condition or disease X is one step removed from that between the indicator and the determination of condition X. The incapacity manifestations are important when examining a patient to determine clinically if he or she has condition X. Though it is conceivable that some will have condition X with minimal clinical manifestations, it would be illogical to assume that the presence of the indicator automatically establishes presence of the incapacity that is associated with the condition.

As we can see in the examination of PET, there are at least three levels of analysis where the relationship between what is detected by a test may be subject to uncertainty. This uncertainty is more likely to occur when the condition in question is of a psychiatric nature where behaviour becomes the basic element in the very definition of the disease itself. These levels of uncertainty exist not only with new technological developments in imaging and genetics, but also with old neuropsychological and physiological tests which are used to substantiate a diagnosis of incapacity.

The future will see the emergence of more sophisticated imaging technologies (such as the synchrotron) that are able to more completely reveal the functioning of tissue that is being studied. When this occurs, the diagnostic process will include technologies that are less expensive and better able to be used in the general care and treatment of patients, as well as the determination of biological substrates of competency. By virtue of its ability to distinguish behavioral normality from abnormality, PET will likely be used in the future for societal control purposes. This application of PET could have serious consequences for personal autonomy and self determination. Sometime in the near future it may be possible to actually distinguish individuals based on differences in their cerebral functioning. Furthermore, PET has the capacity to monitor biologically what the individual is doing by studying the impact of stimulations such as sleep, nutrition, ideas and perhaps even ideological perspectives on brain function.³⁶¹ It has the potential for becoming a very powerful instrument to influence fundamental processes associated

³⁶¹ See P.S. Churchland *Neurophilosophy: Toward a Unified Science of the Mind-Brain* (Cambridge: MIT Press at 403, 1986).

with thought and feeling, to induce conformity, and to delegitimize through biological allegations of incapacity.

3. Neuropsychological Instruments

Neuropsychological instruments are important as adjuncts to the clinical evaluation of capacity. These instruments measure a range of psychological attributes from cognition to sensory ability, organizational skills, affectual states and skills and self-help capacities. None of these instruments on their own can serve as the basis for the determination of incapacity. However, when combined with clinical evaluations, they can add significantly to the validity. In this discussion, some of the most important neuropsychological and other measures of function will be reviewed and discussed in terms of validity and reliability where such information exists. Those instruments which are not discussed are, for the most part, a variation of the major instruments used by neuropsychologists.³⁶²

a. Blessed Dementia Rating Scale (BDRS)

This 22 item scale³⁶³ was originally designed to assess the decline in cognitive efficiency which may be found in old age or dementia. The authors wished to quantify the intellectual and personality deterioration seen in dementia patients. The items relate to competence in personal, domestic and social activities.

The BDRS involves interviewing a close relative or friend of the patient in order to discern how the patient has performed in various domestic and social tasks during the preceding 6 months. Performance is rated as "total incompetence", "partial incompetence" and "competence". Quantified scores on this section of the scale can range from 0 to 28. This provides a rating of dementia along a continuum ranging from a full preserved capacity (0) to extreme incapacity (28).

Reliability

Inter-rater reliability on this test needs to be assessed. The ratings received from others are not truly objective measures of performance.

³⁶² We would like to acknowledge the assistance of Dr. P. Defeudis and M.D. Goltz in the review of the following test instruments.

³⁶³ G. Blessed, B.E. Tomlinson and M. Roth "The Association Between Quantitative Measures of Dementia and of Senile Change in the Cerebral Grey Matter of Elderly Subjects". (1968) 114 *British Journal of Psychiatry* 797.

Validity

In the 1968 paper³⁶⁴ the mean score of a total of 60 demented ($n = 26$), non-demented and psychiatric patients on the BDRS was correlated with mean plaque count on autopsy. The correlation for these two factors was $r = .77$, suggesting that higher scores on the BDRS are associated with higher mean plaque counts. When dementia patients are excluded from the analysis, the correlation drops to $r = .11$. In addition there is a non-significant correlation between age and mean plaque count, in one sample $r = .13$. The authors conclude the "psychological and pathological indices are closely related with one another, possibly through their common association with the underlying degenerative process in the brain".

Comment

Despite the correlation between pathological and psychological measures of dementia, the determination of capacity based on the patient's score on the BDRS is not established. Ecological validity of the test has not been established to date.

b. Clifford Assessment Procedures for the Elderly (CAPE)

The purpose of this instrument³⁶⁵ is to provide a brief method for assessing the cognitive (mental) and behavioral competence of the geriatric population. The CAPE attempts to quantify the degree of dependency of the patient on a cognitive and behavioral level.

The CAPE is comprised of 2 separate assessment procedures, namely the Cognitive Assessment Scale (CAS)³⁶⁶ and the Behavioral Rating Scale (BRS).³⁶⁷ The CAS is a short psychological test aimed at evaluating the existence and degree

³⁶⁴ G. Blessed, B.E. Tomlinson and M. Roth "The Association Between Quantitative Measures of Dementia and of Senile Change in the Cerebral Grey Matter of Elderly Subjects". (1968) 114 *British Journal of Psychiatry* 797.

³⁶⁵ A.H. Pattie and C.J. Gilleard "A Brief Psychogeriatric Assessment Schedule - Validation Against Psychiatric Diagnosis and Discharge from Hospital". (1975) 127 *British Journal of Psychiatry* 489.

³⁶⁶ *Ibid.*

³⁶⁷ C.J. Gilleard and A.H. Pattie "The Stockholm Geriatric Rating Scale: A Shortened Version with British Normative Data". (1977) 131 *British Journal of Psychiatry* 90.

of impairment in mental functioning. It has three components: an information/orientation test; a mental ability test; and a psychomotor test (Gibson Spiral Maze). The BRS asks a rater to rate the individual on what he or she actually does, not what he or she may be able to do, along four dimensions, these being physical disability, apathy, communication difficulties and social disturbance.

The scores on both parts are calculated separately and assigned a "dependency grade" rating. Ratings range from A (for no impairment and independent) to E (severe impairment and maximum dependency).

Norms

Normative data for dependency grade ratings are derived from 9 groups of individuals ranging from normal ($N = 50$), to geriatric developmentally handicapped. Group N 's vary from 20 to 121. Mean age varies from 69.3 years ($sd = 5.4$) to 82.2 ($sd = 5.6$) per group.

Reliability

Test-retest reliability was established on a group of 38 acute geriatric psychiatric admission patients. They were tested at admission and again 3 or 4 days later. Reliability coefficients are as follows: $r = .87$ for information/orientation; $r = .89$ for mental ability; and $r = .79$ for psychomotor ability. Six month test-retest data on 39 residents in a home for the geriatric yielded the following coefficients: $r = .84$ for information/orientation; $r = .74$ for mental ability; and $r = .69$ for psychomotor ability. These scores are suggestive of quite stable scores on this test.

Inter-rater reliability on the BRS for the four subscales range from .45 to .91, with communication difficulties being the most variable parameter.

Validity

Comparative validity is based on a comparison of the information/orientation score with the Wechsler Memory Scale information and orientation score. For this comparison, $r = .90$. It is noteworthy that the questions overlap a great deal, and indeed, that many are virtually identical.

Predictive validity is based on classification on the CAPE and prediction of discharge from hospital. When cut-off points for the various sub-scales of the CAS

were compared to the prediction of discharge at three months, information/orientation yielded 70 per cent correct classification and psychomotor ability yielded 72 per cent correct classification.

Concurrent validity of the BRS was established by comparing BRS scores with living environment. In general, higher BRS scores (more impairment) were found in members of the geriatric population living in more structured environments.

Finally, subscale inter-correlations are high, and the authors feel that this fact is an indication that all subscales contribute to one common factor which reflects the level of dependency of the geriatric person. This hypothesis still needs to be validated via factor analytic work.

c. Cognitive Competency Test (CCT)

The CCT³⁶⁸ attempts to assess one component of overall mental competency, namely, cognitive competency. The authors have adopted a practical assessment approach by simulating daily living situations as much as is possible in an objective assessment. The test evaluates the cognitive skills which are required to maintain safe and independent living. Subtest content varies from filling out a simulated application form, memorizing an appointment, and sorting through financially related materials to verbal reasoning and directional orientation. The test yields an Average Total Score (ATS) which represents the overall percentage of credit obtained on all test items. This score then allows placement of the individual along a continuum of functional competency ranging from totally dependent to totally independent.

Norms

Normative data are based on assessment of 50 community residing geriatric and orthopaedic hospital patients, aged 50 to 93 years. Mean age is 66.6 years. Medical histories were screened to exclude individuals with histories of neurological disorders. Raw score cutoff points for dependent versus independent functioning are determined as follows. A rating of "impaired" is assigned if less than 5 per cent of normals obtained this score or less. A "grey area" rating is assigned if 6 to 20 per cent of normals obtained scores at this level or higher. A rating of "normal"

³⁶⁸ P.L. Wang, K.E. Ennis and S.L. Copland *CCT: Cognitive Competency Test Manual* (Toronto: Mt. Sinai Hospital, 1986).

is obtained if greater than 20 per cent of normals obtained scores at this level or higher.

An ATS of 80 per cent or above was found for all members of the geriatric population living independently in the community. An ATS of less than 80 per cent was found to reflect those individuals who needed at least some assistance.

Reliability

Test-retest reliability in a small group of normal geriatrics ($n = 20$) with a mean test-retest interval of 18.25 days found that significant gains were made only on the verbal memory subtests. The ATS showed a test-retest reliability of .8 with a standard error (SE_{α}) equal to 2.51. Thus, there is less than a 5 per cent chance that the "true" ATS differs from the obtained ATS by more than 5 points.³⁶⁹

Validity

Group comparisons indicated that dementia patients obtained significantly lower group means on all subtests of the CCT as compared to normal geriatrics.

Predictive ecological validity is currently being studied by comparing CCT scores with functional independence in head injured subjects.

Face validity of individual items is high.

d. Community Competency Scale

This scale³⁷⁰ attempts to assess the abilities of the geriatric that are associated with caring for oneself and one's property. The construction of the scale took into account legal definitions, objectives and uses. It has 19 subscales and 166 items. Subscale content varies from judgement and social adjustment to proper diet and management of money. Items require the subject to demonstrate the actual skill whenever possible. This requirement increases the ecological validity of the measure, and allows inferences to be made about everyday living.

³⁶⁹ Ibid.

³⁷⁰ A. Loeb "Validity of the Community Competence Scale with the Elderly". As cited in T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

Subscales and subscale items have been selected on the basis of ratings of category importance by 288 respondents sampling the following populations: judges, mental health professionals performing guardianship examinations, members of the APA gerontological society, and members of the geriatric population advising a local agency for the aging.

Reliability

Internal consistency of the overall scale was found to equal .97 in a sample of psychiatric patients. Test-retest reliability in the same sample at seven weeks was .94.³⁷¹ Internal consistency in a sample of geriatric patients was .93.³⁷² Inter-rater reliability was .94 in this same sample.

Norms

This scale lacks a large normative sample for the geriatric population, although some smaller samples have been reported.³⁷³ It is generally felt that the scale could benefit from the establishment of standard scores.³⁷⁴

Validity

Construct validity has not yet been established via factor analytic studies. Group comparisons have yielded significantly different scores for members of the geriatric population in three different living situations. In addition, 89 per cent of a geriatric sample has been correctly classified with respect to independence using only 11 of the 19 subscales.³⁷⁵

³⁷¹ T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

³⁷² P.A. Loeb "Validity of the Community Competence Scale with the Elderly". As cited in T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

³⁷³ Ibid and T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

³⁷⁴ T. Grisso *Evaluating Competencies: Forensic Assessments and Instruments* (New York: Plenum Press, 1986).

³⁷⁵ H.R. Searight, J. Olver and T. Grisso "The Community Competence Scale: Preliminary Reliability and Validity". (1983) 11. *American Journal of Community Psychology* 609.

e. Dementia Rating Scale

This scale³⁷⁶ is designed to sample the behaviour of patients with severe deficits in higher cognitive functions. The abilities sampled include perceptual, cognitive, memory and motor skills, with items being geared well below the average adult level. They are hierarchically arranged, such that adequate performance on the initial item of a subtest allows that subtest to be discontinued. The subject is then given credit for that section under the assumption that he can complete it without error.

Norms

There is no record of a normative sample, however the cut-off for impaired performance is 133 out of a possible 158 points.

Reliability

Test-retest reliability coefficients range from .61 to .97 in a sample of 30 Alzheimer's patients when the DRS was administered twice within a one week interval.

Validity

Concurrent validity is based on a comparison between the DRS, the Wechsler Adult Intelligence Scale (WAIS) and the Paired Associates subtest of the Wechsler Memory Scale (WMS). Both normal and demented subjects were tested. If subjects attained a WAIS IQ of 85 or greater, the DRS score was 140 or greater.

f. Global Deterioration Scale

This is a clinical rating scale³⁷⁷ for the assessment of primary degenerative dementia. It identifies seven stages of cognitive deterioration ranging from "Normal" to "Very Severe Cognitive Decline". Classification at each level is determined by a combination of clinical rating and performance on several psychometric measures, including the Guild Memory Tests, the WAIS vocabulary

³⁷⁶ J.M. Coblenz, S. Mattis, L.H. Zingesser, S.S. Kasoff *et al*, "Presenile Dementia: Clinical Aspects and Evaluation of Cereospinal Fluid Dynamics". (1973) 29 Archives of Neurology 299.

³⁷⁷ B. Reisberg, S.H. Ferris, M.J. DeLeon and T. Crook "The Global Deterioration Scale for Assessment of Primary Degenerative Dementia". (1982) 139 American Journal of Psychiatry 1136.

subtest and the Mental Status Questionnaire. Each of the seven stages has been given a brief verbal description which covers elements of personal orientation, memory, degree of confusion, directional orientation, finances, complex tasks, flattening of affect and social withdrawal. Note that none of these areas is evaluated objectively; rather, these elements are incorporated subjectively into the clinician's rating of cognitive decline.

Reliability

No test-retest or inter-rater reliability coefficients are reported.

Validity

Concurrent validity was assessed by correlating Global Rating Scale ratings with various psychometric measures including reaction time, memory, psychomotor speed and the Inventory of Psychic and Somatic Complaints of the Elderly. Correlation coefficients range from .02 to .64, with the highest overall correlations seen on Buscke's verbal learning, Peterson and Peterson Short Term Retention and Design Memory. Ecological validity and predictive validity have not been addressed.

g. Geriatric Mental State Schedule

The Geriatric Mental State Schedule (GMSS)³⁷⁸ is a semi-structured clinical interview procedure designed for the diagnosis of mental state in the geriatric population. The basic scale is derived from the Present State Examination (PSE). However, cognitive and mental status items have been added for use with older adults. The GMSS is comprised of 541 items, 209 of which have been added for use with geriatrics. Most items are rated on a five point scale from "absent" to "present: severe, frequent and persistent". The interview requires 30 to 40 minutes to administer. It allows psychiatric/functional classification of subjects with a symptom profile.

³⁷⁸ J.R.M. Copeland, M.J. Kelleher, J.M. Kellet, A.J. Gourlay, B.J. Gurland, J.L. Fleiss and L. Sharpe "A Semi-Structured Clinical Interview for the Assessment of Diagnosis and Mental State of the Elderly: The Geriatric Mental State Schedule. I Development and Reliability". (1976) 6 *Psychological Medicine* 439.

Norms

None reported.

Reliability

Inter-rater reliability regarding the primary diagnostic category assigned to the patient was 85 per cent (17/20 cases). Partial agreement was reached in 95 per cent of the cases and total diagnostic agreement occurred in 60 per cent of cases. The mean inter-rater agreement taken across all items of the schedule was 72 per cent.

Validity

Validity of the schedule is based upon the observation of markedly different profiles of section scores for patients with and without organic mental disorders. In addition, dementia patients show little change in symptoms at 3 month follow-up, whereas affective patients show a decline in symptoms. The authors conclude that this suggests that the GMSS is sensitive to changes in Mental Status.

h. Kendrick Battery for the Detection of Dementia in the Elderly

The Kendrick Battery³⁷⁹ is comprised of two subsections. The first subsection, the Object Learning Test, involves the recall of everyday objects which the subject is allowed to view for a brief time. The objects are pictured on 4 stimulus cards, and each stimulus card has progressively more items on it. Some items are repeated across stimulus cards. The second subsection is a Digit Copying Task, the idea being that the subject copy the digits presented to him/her as rapidly as possible. The diagnostic function of the test lies in the computation of a change function. This requires that the test be re-administered approximately six weeks after initial testing, thus obtaining two scores for each subscale.

³⁷⁹ D.C. Kendrick, A.J. Gibson and I.C.A. Moyes "The Revised Kendrick Battery: Clinical Studies". (1979) 18 *British Journal of Social and Clinical Psychology* 329.

The Kendrick Battery is designed to assess those cognitive abilities most "sensitive" to aging. Administration time is approximately 15 minutes, and the authors caution that the test is not appropriate for individuals with a Mill Hill Vocabulary IQ below 70, assuming a mean of 100 and a standard deviation of 15. In addition, the test is not suitable for diagnostic use with institutionalized patients.

Norms

Normative data are available for ages 55 to 84. The total normative sample is $N = 188$. Age scaled scores were derived for total Object Learning Test and Total Digit Copying Test scores since these scores were significantly correlated with age in the normal group.

Reliability

Test-retest reliability for the object learning test at 24 hours is .92 for form A ($N = 20$) and .91 for form B ($N = 20$). Inter-correlations between first and second administrations of this subscale are significant at the $p < .01$ level for normal, depressed and demented subjects. In addition, both normal and depressed subjects showed significant improvement on the second administration of this test, whereas demented subjects showed no such improvement.

Immediate test-retest reliability for the Digit Copying Test is .97 ($N = 80$). Inter-correlations between first and second administrations of the test are significant at the $p < .01$ level for normal, depressed and demented subjects. Again, normal and depressed subjects show significant improvement on this subscale after a six week interval. Demented subjects show no such improvement.

Validity

Construct validity, as assessed by factor analysis, shows the emergence of 3 factors in both normals and depressed patients. These are the Object Learning Test, the Digit Copying Test, and "intelligence". Factor structure cannot be interpreted for dementia patients.

Discriminative validity has been found in the test's ability to discriminate between demented and non-demented subjects when used in a test-retest situation.

Cross-validation of the classification accuracy of the Kendrick Battery and psychiatric diagnosis yielded a Rho coefficient of .63 after the first testing, and a Rho coefficient of .70 after the second assessment.³⁸⁰

i. Mental Status Questionnaire (MSQ)

The purpose of these authors was to develop a brief, objective and quantitative measure of mental functioning related to cerebral impairment.³⁸¹ It is comprised of 31 questions covering orientation, memory, calculation and general personal information. Ten of these items were selected to obtain a quantitative index of mental functioning.

Reliability

Information on reliability is not reported.

Validity

Of 1077 patients tested, 94 per cent were given the same diagnosis with the Mental Status Questionnaire and clinical psychiatric diagnosis. With a score of 10 on the MSQ (normal), 94 per cent were rated psychiatrically normal as well. With a score of 0 on the MSQ (severe management problem), 95 per cent were deemed to have chronic brain syndrome as determined by psychiatric diagnosis.

j. Mini-Mental State (MMS)

The intent of these authors was to provide a brief, quantitative assessment of cognitive performance which would be suitable for use with patients who will cooperate well for only brief periods of time.³⁸² These authors propose that the MMS provides a thorough assessment within the cognitive realm, although it provides no assessment of mood, abnormal mental experiences or forms of thinking. Others have argued that although the MMS is a valuable screening tool for the determination of cognitive impairment, it cannot provide valid information about

³⁸⁰ R.G. Knight and B.M. Moroney "An Investigation of the Validity of the Kendrick Battery for the Detection of Dementia in the Elderly". (1985) 7 *International Journal of Clinical Neuropsychology* 147.

³⁸¹ R.L. Kahn, A.I. Goldfarb, M. Pollack and A. Peck "Brief Objective Measures for the Determination of Mental Status in the Aged". (1960) 117 *American Journal of Psychiatry* 326.

³⁸² M.F. Folstein, S.E. Folstein and P.R. McHugh "Mini-Mental State - A Practical Method for Grading the Cognitive State of Patients for the Clinician". (1975) 12 *Journal of Psychiatric Research* 189.

specific cognitive functions, since many functions are sampled only by a single brief item.³⁸³ It samples briefly across a wide range of cognitive abilities, including immediate memory, comprehension, orientation and attention. An individual scoring 23 or less out of a possible 30 points is assigned a diagnosis of dementia or delirium.

Reliability

Test-retest reliability was assessed at 24 hours with the same examiner administering both tests to a group of depressed patients. The correlation between the two tests was significant at .88 ($p < .0001$). A 28 day retest of clinically stable psychiatric patients yielded a significant correlation coefficient of .988 ($p < .0001$).³⁸⁴ The sample of geriatrics (ages 60 to 80+) included in test-retest data is $N = 41$.

Validity

The MMS was found to separate demented from affective patients with and without cognitive deterioration, and normal subjects. The authors conclude that the MMS classification agreed with clinical impression of the presence of cognitive difficulty and numerically agreed with severity.³⁸⁵

Dementia patients have a lower group mean score on the MMS than psychiatric groups. However, there is a greater degree of score variability within groups.

Concurrent validity of the MMS with WMS Memory Quotient (MQ), WAIS, VIQ, PIQ and CAT scan measures of atrophy has been examined. Correlation coefficients are as follows: MMS and VIQ $r = .40$; MMS and PIQ $r = .56$; MMS and MQ $r = .58$; MMS and CAT scan $r = .35$. All correlation coefficients were significant -- at least at the $p < .05$ level.³⁸⁶ There was no significant correlation

³⁸³ F.A. Huppert and E. Tym "Clinical and Neuropsychological Assessment of Dementia". (1986) 42 Medical Bulletin 11.

³⁸⁴ M.F. Folstein, S.E. Folstein and P.R. McHugh "Mini-Mental State - A Practical Method for Grading the Cognitive State of Patients for the Clinician". (1975) 12 Journal of Psychiatric Research 189.

³⁸⁵ Ibid.

³⁸⁶ J.R. De Paulo, M.F. Folstein and B. Gordon "Psychiatric Screening on a Neurological Ward". (1980) 10 Psychological Medicine 125.

found between the MMS, the General Health Questionnaire, and emotional state measure.

Anthony, Niaz, LeResche, VonKorff *et al* report 87 per cent sensitivity and 82 per cent specificity in classifying dementia and delirium, with the cut-off score of 23 when a psychiatrist standardized clinical diagnosis was used as a criterion.³⁸⁷ However, the false positive rate in this study was 39 per cent. Other false positive rates of 33 per cent and 35 per cent have also been reported.³⁸⁸ It is also noteworthy that very mild cases of dementia may be overlooked using this cut-off criterion.

Comment

The MMS was designed to provide a brief cognitive screen for mental impairment, and no mention of assessing capacity on the basis of MMS scores has been made. The authors conclude that "... the MMS cannot be expected to replace a complete clinical appraisal in reaching a final diagnosis of any individual patient".³⁸⁹ Due to the extensive clinical experience with this test and its suitability for use as a brief preliminary check, we have employed a number of elements of the MMS in our proposed screening test of capacity. Further comments on this instrument and its limitations will be made in the section discussing the proposed assessment protocol.

k. Neurobehavioural Cognitive Status Exam (NCSE)

The NCSE³⁹⁰ was designed to assess intellectual functioning in five major areas: Language, Constructions, Memory, Calculations and Reasoning. In addition, it provides an assessment of attention, level of consciousness and orientation. The test is administered such that a difficult, skill demanding "screen" item is given first in each category. These "screen" items may also require sustained attention. If a

³⁸⁷ J.C. Anthony, U. Niaz, L.A. LeResche, M.R. VonKorff and M.F. Folstein "Limits of the 'Mini-Mental State' as a Screening Test for Dementia and Delirium Among Hospital Patients". (1982) 12 *Psychological Medicine* 397.

³⁸⁸ F.A. Huppert and E. Tym "Clinical and Neuropsychological Assessment of Dementia". (1986) 42 *Medical Bulletin* 11.

³⁸⁹ M.F. Folstein, S.E. Folstein and P.R. McHugh "Mini-Mental State - A Practical Method for Grading the Cognitive State of Patients for the Clinician". (1975) 12 *Journal of Psychiatric Research* 189.

³⁹⁰ The Northern California Neurobehavioral Group, Inc., *Manual for the Neurobehavioral Cognitive Status Exam* (1983).

"screen" is passed, ability in that category is assumed to be intact and no further testing is done in that area. If the "screen" item is failed, a series of items are administered in order of increasing difficulty. In general, "screens" are demanding enough that they are failed by 10 to 30 per cent of the normal population. A cognitive "profile" based on performance across categories is provided. Item content in this instance resembles item content of the WAIS and WMS in both style and scoring procedure.

Norms

Norms are available for 3 age ranges: 20 to 39, 40 to 66, and 70 to 92 years. There were a total of 60 individuals in the first two age ranges combined, and 50 in the 70 to 92 age group.

Reliability

No test-retest data are reported because of the ceiling effect in normal individuals. There are too few items administered to the sample to conduct split-half reliability analyses.

Validity

No factor analytic studies have been reported to date. No validity data are reported.

The authors do observe that the Mean profile scores for patients (neurosurgery group) fall "significantly" outside of the "normal" range.

1. Rivermead Behavioral Memory Test (RBMT)

The purpose of the RBMT³⁹¹ is to assess and detect impairment in memory abilities which may affect everyday functioning, as well as to monitor the effectiveness of treatment in everyday functioning. Assessment procedures utilize analogues of everyday memory situations which may prove to be problematic for brain-injured or otherwise impaired individuals. Examinees are required to remember or carry out some banal task, or to retain information essential to adequate everyday functioning. Subtests include recalling a name, remembering a

³⁹¹ B. Wilson, J. Cockburn and A. Baddeley *The Rivermead Behavioral Memory Test Manual* (Reading: Thames Valley Test Company, 1985).

hidden belonging, remembering an appointment, recognition memory of faces and objects, prose recall and orientation. In addition, the RBMT provides 4 parallel forms, thereby reducing practice effects which are often observed in serial assessments. The RBMT provides both a screening score, where 12 items are simply scored on a pass-fail basis, and a more comprehensive profile score, which may be useful when an individual's screening score lies in the impaired range.

Norms

The cut-off score for impaired performance on the RBMT is 3 or more failures on the screening score portion of the test. All-in-all, screening scores of 10 to 12 represent normal memory function, 7 to 9 represents mild memory impairment, 3 to 6 represents moderate memory impairment and scores of 0 to 2 represent severe memory impairment. Preliminary data suggest that non-brain damaged subjects between the ages of 16 and 65 score within the normal range. There is a slight decline in the over 65 age range, with a proportion of subjects scoring in the mildly impaired range. Adjusted norms are provided for individuals with expressive language problems.

Reliability

Inter-rater reliability in two separate studies was 100 per cent, with the first study using two independent raters, and the second study using ten independent raters.

Test-retest reliability coefficients have been found to be $r = .78$ for the screening score, and $r = .82$ and $r = .85$ in two separate studies for the profile score. Parallel-forms reliability coefficients range from .67 to .88 respectively, with coefficients for the profile scores being higher than those for the screening scores.

Validity

Ecological validity has been examined to some degree. It was found that correlations between RBMT scores and therapist's observations of the number of memory failures in the areas assessed by the RBMT were in the order of $r = .75$. Scores on the RBMT were also significantly correlated with scores on Warrington's Recognition Memory Test, Digit Span, Logical Memory of the Wms, and Paired Associate learning at the $p < .001$ level. Ratings of impaired memory functioning by therapists versus the RBMT were also significantly correlated at the $p < .001$.

level, although no mention of the rating of severity of memory impairment was made.

Comparison studies of the RBMT with an index of capacity have not been conducted to this point. In addition, attempts to isolate groups of patients using cluster analyses of RBMT scores have not been successful.

m. Wechsler Adult Intelligence Scale (WAIS and WAIS-R)

The essential purpose of these tests³⁹² is to provide a basic assessment of intelligence, that is, to assess "an individual's potential for purposeful and useful behaviour".³⁹³ The primary purpose of these tests is not to assess the individual's cognitive or functional abilities, since intelligence may not necessarily be adaptive in and of itself. Cognitive skills may be the requisite for functional and adaptive behaviour but they are not the sole determinants thereof.³⁹⁴ As such, although two individuals may demonstrate equivalent performance on the WAIS and WAIS-R, they may differ substantially in their ability to cope with the environment. In fact, a significant proportion of the test variance is not accounted for in factor analytic studies, suggesting the importance of non-intellective factors in determining behaviour. Approximately 20 per cent of the items on the WAIS-R are either new, or substantially changed from the equivalent items on the WAIS.

Norms (WAIS)

Normative data are based on test scores collected from 850 individuals aged 16 to 64 years, divided into seven age ranges. The proportion of individuals in the sample by region, occupation and education approaches that of the U.S. population in general. Standardized norms are provided for the individual subscales as well as the composite IQ scores. Subscale norms have a mean of 10 and a standard deviation of 3, whereas IQ scales have a mean of 100 and a standard deviation of 15.

³⁹² D. Wechsler *WAIS Manual: Wechsler Adult Intelligence Scale* (New York: The Psychological Corporation, 1955) and D. Wechsler *WAIS-R Manual: Wechsler Adult Intelligence Scale - Revised Manual* (New York: The Psychological Corporation, 1981).

³⁹³ D. Wechsler *WAIS-R Manual: Wechsler Adult Intelligence Scale - Revised Manual* (New York: The Psychological Corporation, 1981).

³⁹⁴ *Ibid.*

Reliability (WAIS)

Three age groups were selected for the computation of reliability coefficients. Split-half reliability coefficients for the individual subtests range from .60 to .96. Reliability for the IQ scores are as follows: $r = .96$ for VIQ, $r = .93$ for PIQ and $r = .97$ for FSIQ. Standard errors of the Mean (SE_M) were also calculated. These are $SE_M = 3.00$ for VIQ, $SE_M = 3.97$ for PIQ and $SE_M = 2.60$ for FSIQ. These three composites are generally the most reliable measures obtained from the WAIS, and are more stable than any individual subtest scores.

Validity (WAIS)

Inter-correlations between the WAIS and the Stanford-Binet Scale, Form L, were computed in a sample of 52 white male adults. Correlations with the Stanford Binet Scale are $R = .86$ for Viq, $r = .69$ for PIQ and $r = .85$ for FSIQ.

Factor analyses of the WAIS have delineated three basic factors, these being labelled as "Verbal Comprehension", "Perceptual Organization" and "Freedom from Distractibility".³⁹⁵ Some studies also report the emergence of a "g" or "general factor".³⁹⁶

In studies using the WAIS to identify brain damaged patients, Kane, Parsons and Goldstein have reported 89.13 per cent of control subjects correctly classified and 80.43 per cent of brain-damaged patients correctly classified on the basis of both Verbal and Performance IQ.³⁹⁷ These authors also report that the accuracy of this classification is not borne out on a case by case basis.

Norms (WAIS-R)

Normative data for the WAIS-R have been collected on a sample of 1880 individuals in the USA, ranging in age from 16 years 0 months to 74 years 11 months. The percentage of people from various age, occupational, educational,

³⁹⁵ K. Parker "Factor Analysis of the WAIS-R at Nine Age Levels between 16 and 74 Years". (1983) 51 *Journal of Consulting and Clinical Psychology* 302.

³⁹⁶ A.B. Silverstein "Factor Structure of the Wechsler Adult Intelligence Scale - Revised". (1982) 50 *Journal of Consulting and Clinical Psychology* 661.

³⁹⁷ R.L. Kane, O.A. Parsons and G. Goldstein "Statistical Relationships and Discriminative Accuracy of the Halstead-Reitan, Lucia-Nebraska, and Wechsler IQ Scores in the Identification of Brain Damage". (1985) 7 *Journal of Clinical and Experimental Neuropsychology* 211.

racial and urban/rural residential groups within the standardization sample is closely matched to the proportion of these individuals in the general U.S. population. Normative comparisons are made on the basis of standard scores with a mean of 100, standard deviation of 15 for the composite IQ scores and a mean of 10, standard deviation of 3 for the individual subscale scores. Age scaled scores are provided for all of the individual subtests.

Reliability (WAIS-R)

Reliability coefficients are reported for all subtests. Test-retest reliability coefficients are given for Digit Span and Digit Symbol, and split-half reliability coefficients are reported for all other subtests. Reliabilities range from .52 to .96, with only 6 coefficients falling below $r = .70$. The average test-retest reliabilities for the composite scales are as follows: $r = .97$ for VIQ, $r = .93$ for PIQ and $r = .97$ for FSIQ.³⁹⁸ The average Standard Error of Measurement (SE_M) across age groups for the composite scales are as follows: $SE_M = 2.74$ for VIQ, $SE_M = 4.14$ for PIQ and $SE_M = 2.53$ for FSIQ. Thus, the 95 per cent confidence interval for an individual's "true" FSIQ will be 5.06 points. In addition, scoring reliability of the WAIS-R has been shown to be adequate, in that across 39 scorers, 77 per cent of the scores were found to be within 1 SE_M of the "true" score.³⁹⁹ Naglieri presents confidence intervals across age ranges for VIQ, PIQ and FSIQ.⁴⁰⁰ Intervals are reported at the 85, 90, 95 and 99 per cent level of confidence.

A caution presented by Matarazzo and Herman concerns the high base rate of significant VIQ-PIQ differences in the test-retest subjects of the WAIS-R standardization sample ($n = 119$).⁴⁰¹ This may represent a high base rate within the population and indicates that some caution must be exercised when interpreting these differences.

³⁹⁸ D. Wechsler *WAIS-R Manual: Wechsler Adult Intelligence Scale - Revised Manual* (New York: The Psychological Corporation, 1981).

³⁹⁹ J.J. Ryan, A. Prifitera and L. Powers "Scoring Reliability on the WAIS-R". (1983) 51 *Journal of Consulting and Clinical Psychology* 149.

⁴⁰⁰ J.A. Naglieri "Two Types of Tables for Use With the WAIS-R". (1982) 50 *Journal of Consulting and Clinical Psychology* 319.

⁴⁰¹ J. Matarazzo and D.O. Herman "Base Rate Data for the WAIS-R: Test-Retest Stability and VIQ-PIQ Differences". (1984) 6 *Journal of Clinical Neuropsychology* 351.

In factor analytic studies of the WAIS-R, the emergence of three general factors has been documented. These have been labelled "verbal comprehension", "perceptual organization" and "memory". Parker has reported that the WAIS and the WAIS-R both have this same basic underlying factor structures, but he has labelled the third factor "freedom from distractibility".⁴⁰² Blaha and Wallbrown also reported finding the verbal and spatial-perceptual factors, but the third factor they reported was a "general" or "g" factor on which all 11 subtests loaded, lending credence to the notion of a Full Scale IQ.⁴⁰³ Factor analysis of scores obtained by psychiatric patients also yielded a 3 factor solution comparable to that found in the normal population.⁴⁰⁴

Comment

The WAIS and WAIS-R are the most extensively studied and standardized of the neuro-psychological tests that have been reviewed for their applicability to the assessment of capacity. However, since these instruments assess intelligence and not cognitive or functional abilities, these tests have limited usefulness with respect to the assessment of capacity. The measurement of adaptive behaviour, which is not closely correlated with intelligence, is more significant in this regard and should be the focus of testing.

n. Wechsler Memory Scale

The purpose of the Wechsler Memory Scale (WMS)⁴⁰⁵ was originally to assess memory functions. The test itself samples a wide range of abilities, including personal and current information, orientation, and immediate recall of short paragraphs, numbers, word pairs and geometric figures. The test yields a Memory Quotient (MQ) which is score based on a mean of 100 and a standard deviation of 15. It is based on a computation that keeps the mean MQ of any particular age group equivalent to the mean Bellevue Scale IQ for that same age group.⁴⁰⁶ The

⁴⁰² K. Parker "Factor Analysis of the WAIS-R at Nine Age Levels between 16 and 74 Years". (1983) 51 Journal of Consulting and Clinical Psychology 302.

⁴⁰³ J. Blaha and F.H. Wallbrown "Hierarchal Factor Structure of the Wechsler Adult Intelligence Scale - Revised". (1982) 50 Journal of Consulting and Clinical Psychology 652.

⁴⁰⁴ L. Atkinson and J.J. Cyr "Factor Analysis of the WAIS-R: Psychiatric and Standardization Samples". (1984) 52 Journal of Consulting and Clinical Psychology 714.

⁴⁰⁵ D. Wechsler and C.P. Stone *Wechsler Memory Manual* (New York: The Psychological Corporation, 1945).

⁴⁰⁶ *Ibid.*

unofficial addition of a delayed recall component by Russell enhances the clinical utility of the WMS.⁴⁰⁷

Norms

Normative data for the scale are still based on Wechsler's original 1945 sample of 200 normal subjects seen at Bellevue Hospital in New York. The age range for these subjects is 25 to 50 years of age. Norms were extrapolated to older and younger age groups. The proportion of males and females in this group was not reported. Some preliminary norms for older subjects (age 60 and over) were developed by Cauthen.⁴⁰⁸ Age corrections are not provided. Rather, these norms provide an idea of what may be considered to be "within normal limits" for older adults.

Reliability

There are no reliability data provided by Wechsler in the original manual for the WMS. Test-retest reliability quotients vary greatly depending upon the population studied. In schizophrenics, coefficients range from $r = .17$ to $r = .70$ after prefrontal lobotomy. Other test-re-test studies have reported no change in MQ group means.⁴⁰⁹

Tests of split-half reliability report a coefficient of $r = .75$, suggesting that the WMS does not measure a single "memory factor". Subjects in this study were children and adolescents.⁴¹⁰

Alternate form reliability studies have reported correlations in the range of $+.80$ to $+.83$.⁴¹¹ Subjects in one of these studies were depressed patients before

⁴⁰⁷ E.W. Russell "A Multiple Scoring Method for the Assessment of Complex Memory Functions". (1975) 43 *Journal of Consulting and Clinical Psychology* 800.

⁴⁰⁸ N.R. Cauthen "Extension of the Wechsler Memory Scale Norms to Older Age Groups". (1977) 33 *Journal of Clinical Psychology* 208.

⁴⁰⁹ G.P. Prigatano "Wechsler Memory Scale: A Selective Review of the Literature". (1978) 34 *Journal of Clinical Psychology* 816.

⁴¹⁰ A. Ivinskis, A. Allen and E. Shaw "An extension of Wechsler Memory Scale Norms to Lower Age Groups". (1971) 27 *Clinical Psychology* 354.

⁴¹¹ G.P. Prigatano "Wechsler Memory Scale: A Selective Review of the Literature". (1978) 34 *Journal of Clinical Psychology* 816.

and after unilateral ECT and the coefficient was merely estimated in the other study.

Validity

Factor analytic studies have demonstrated that the subtests of the WMS load fairly consistently on two basic factors, these being a "Memory" factor and a "Freedom from Distractibility" factor, in patient (mainly neurological and psychiatric) populations.

Studies in normal subjects have reported slightly different findings. The "Freedom from Distractibility" factor does not clearly emerge, and the "Memory" factor emerges more as two separate factors reflecting "simple versus hard learning". In addition, inter-subtest correlations are reportedly low.

Correlations between MQ and WAIS Full Scale IQ have also been studied. These studies indicate that correlations range from $r = .75$ to $r = .83$ in neurological, head-injured and psychiatric patients. In children and adolescents, the inter-correlations range from $r = .44$ to $r = .56$.⁴¹²

Milner has suggested that an MQ of 12 points below a Full Scale IQ score is reflective of a verbal memory deficit.⁴¹³ Korsakoff patients have been found to have normal FIQs, but MQs 16 to 20 points below normal limits, again suggesting that lowered MQs are reflective of a verbal memory deficit.

Construct validity studies aimed at assessing whether the WMS MQ is indeed a reflection of verbal memory, have demonstrated that in right and left hemisphere thalamectomy patients, only the left hemisphere patients showed a significant post operative drop in MQ, whereas both groups showed a drop in IQ scores. Milner⁴¹⁴ reports that left temporal lobectomy patients show lower postoperative MQ scores than do right temporal lobectomy patients. This pattern is observed mainly when the lesion is within the temporal lobe, and may not be seen in frontal lobe

⁴¹² G.P. Prigatano "Wechsler Memory Scale: A Selective Review of the Literature". (1978) 34 *Journal of Clinical Psychology* 816.

⁴¹³ B. Milner "Psychological Aspects of Focal Epilepsy and its Neurosurgical Management". (1975) 8 *Advances in Neurology* 299.

⁴¹⁴ *Ibid.*

lesions.⁴¹⁵ In addition, several studies have reported lowered MQ in the presence of average IQ in amnesic patients of varying etiology.⁴¹⁶

In general, studies aimed at using the WMS to identify patients with and without identifiable brain dysfunction have been largely unsuccessful. The MQ does not allow this discrimination to be made. Studies which have designed special scoring systems to attempt to increase discriminability have also largely failed to do so. The value of the WMS as a "screening" test for brain dysfunction is doubtful.

a. Wechsler Memory Scale - Revised (WMS-R)

As with its predecessor the WMS, the purpose of the WMS-R⁴¹⁷ is to assess the major dimensions of memory functioning. The author explains that it is intended to be a diagnostic and screening device for use as part of a more general clinical examination which requires the assessment of memory functions. The test provides five composite scores: Verbal, Memory, Visual Memory, General Memory (Verbal Memory plus Visual Memory), Attention/Concentration and Delayed Recall. A general assessment of orientation is also included in the test, but not in any of the composite scores. Raw scores are converted to Index Scores which have a mean of 100 and a Standard deviation of 15. Unlike the WMS, an MQ is not reported. This score is now represented by the General Memory Index and excludes subtests of attention/concentration. Whether this is now a more "pure" indicator of memory functions has yet to be established.

Norms

A total of 300 normal individuals across 6 age ranges were included in the standardization sample. Subjects were subdivided to include 50 cases in each of these 6 age groups. Of note is the fact that normative data are provided across nine age ranges. Norms were interpolated by an estimation procedure for the groups not sampled. The mean WAIS-R FSIQ for the standardization sample is 103.9 across all age groups. This represents an IQ of .26 standard deviations above the assumed population mean of 100, and although this is not a significant

⁴¹⁵ V. Logue, M. Durward, R.T.C. Pratt, W. Piercy and W.L.B. Nixon "The Quality of Survival After Rupture of an Anterior Cerebral Aneurysm". (1968) 114 *British Journal of Psychiatry* 137.

⁴¹⁶ G.P. Prigatano "Wechsler Memory Scale: A Selective Review of the Literature". (1978) 34 *Journal of Clinical Psychology* 816.

⁴¹⁷ D. Wechsler *WMS-R: Wechsler Memory Scale - Revised Manual* (New York: The Psychological Corporation, 1987).

difference and well within 1 SE_M , it does suggest that the norms for the WMS-R may be anchored slightly higher than desired. As such, this fact must be kept in mind when evaluating a subjects performance on the WMS-R.

Reliability

Test-retest coefficients for the Mental Control, Visual Paired Associates and Verbal Paired Associates subtests are $r = .51$, $r = .58$ and $r = .60$ respectively. The rest of the subtests were assessed using internal consistency (split-half) analyses. These coefficients range from .44 to .88. For the Composite Index Scales the reliability coefficients (internal consistency) are as follows: $r = .81$ for General Memory, $r = .90$ for Attention/Concentration, $r = .77$ for Verbal Memory, $r = .70$ for Visual Memory and $r = .77$ for Delayed Recall across all age ranges sampled ($N=151$ for the total sample). Inter-scorer reliability was assessed for Logical Memory and Visual Reproduction, and the coefficients were .99 and .97 respectively. The Standard Error of Measurement (SE_M) for the various indexes are as follows: $SE_M = 6.81$ for General Memory, $SE_M = 4.86$ for Attention/Concentration, $SE_M = 7.29$ for Verbal Memory, $SE_M = 8.47$ for Visual Memory and $SE_M = 7.46$ for Delayed Recall.

Validity

Principal components analyses report the emergence of two major composite scores, namely General Memory and Attention/Concentration. This factor structure was found across the entire standardization sample, as well as separately in both a younger (age 16-44) and an older (age 55-74) sub-sample. A similar factor structure was found in a mixed clinical sample of patients with suspected or documented memory impairment.

Chelune and Bornstein have reported that left hemisphere patients ($N = 59$) score significantly lower ($p < .009$) on the Verbal Memory Composite Index than do right hemisphere patients ($N = 56$).⁴¹⁸ These authors also report a double dissociation of right and left hemisphere patients on verbal and visual memory measures. This result lends some preliminary support to the WMS-R as a modality-specific measure of memory.

⁴¹⁸ C.J. Chelune and R.A. Bornstein "WMS-R Patterns Among Patients With Unilateral Brain Lesions". (1988) 2 *Clinical Neuropsychologist* 121.

F. REVIEW OF CRITERIA AND INSTRUMENTS - SUMMARY

There is a vast and growing array of test instruments, techniques and technologies which may be employed in the assessment of capacity. The rapidly evolving state of the art with respect to the tools which may be employed in this regard, and the requirement for flexibility, precludes our recommendation of specific instruments for the assessment of capacity. What can and will be recommended is criteria and some guiding principles to be implemented during formal assessments using the best available instruments, tools and technologies.

XIV. ELEMENTS OF DECISIONAL CAPACITY

A. ESSENTIAL REQUIREMENTS FOR THE MAKING OF DECISIONS

At a minimum, four conditions must be met before a decision can be said to have been made, an individual must:⁴¹⁹

- 1) Be informed that a decision is required of them.
- 2) Obtain information relevant to that making of the decision.
- 3) Process the information in the course of making the decision.
- 4) Communicate the decision.

An inability to communicate⁴²⁰ may result in an inappropriate determination of incapacity in many situations. Thus, as a necessary precondition to the performance of the assessment, efforts must be made to identify and address any communication difficulties. This requires that all reasonable attempts be made to overcome linguistic, social or cultural differences between the decision maker and assessor, and that possible medical or other physiologically based impediments be diagnosed and remedied if feasible. Wherever possible, the assessment should be performed in the mother tongue of the decision maker. Where this suggestion cannot be implemented, an interpreter should be employed to assist in this process. The use of the mother tongue as the language of assessment is particularly important when evaluating children.⁴²¹

Ability to communicate is also implicated in step 2), but more significantly; this stage reminds us that an "informed" decision requires that the individual has

⁴¹⁹ M.P. Alexander "Clinical Determination of Mental Competence: A Theory and Retrospective Study". (1988) 45 Arch. Neurol. 23 at 23-24 identifies three elements in the making of a competent decision:

- 1) Recognition that a decision must be made
- 2) Activation of cognitive mechanisms to process the decision
- 3) Implementation of the decision.

Center for Research & Education in Human Services, "Choices and Obligations - A Look at Personal Guardianship - Policy Analysis Paper No. 3" (Toronto: Ministry of Community and Social Services, 1988) at 9 cites Marlett as the source of "a conceptual model that consists of cognitive skill, functional competence, and social knowledge as a basis for such a determination."

⁴²⁰ Problems with communications could be a result of a wide range of social, cultural or physical factors, and care must be taken to avoid wrongly labelling as incompetent those individuals whose only incapacity relates to such sources of impaired communications abilities.

⁴²¹ In this regard the importance of the provision of French language health care services to children was stressed in the submission from Denis Fortin of the Ministry of Health French Language Health Services branch of October 27, 1989.

been given the material information on which to make a decision. As noted previously, a number of empirical studies have, in our opinion, been fatally flawed by the failure of the researchers to ensure that the test subjects had been provided with the information on which they were later tested. The collection of information also involves the interpretation and internalization of "facts" and highlights the impossibility of divorcing facts from their social context. All information includes both "fact" and "opinion" components.⁴²² This raises the problem of distinguishing between capable but dissident interpretations of information and those which are the result of incapacity. Therefore, allegations of incapacity must only be made on this basis under the most rigorous procedural safeguards and care must be taken to ensure that individuals' preferences and autonomy are recognized as being paramount.

The transition from 2) to 3) requires that the decision maker must be able to remember the relevant information long enough to be able to process it and make a decision. The ability to process information lies at the heart of decisional capacity and gives rise to the greatest difficulties in the assessment of capacity. The tests of information processing ability and the other parameters of capacity will be discussed in more detail in the following sections.

B. ELEMENTS OF ASSESSMENT OF DECISION MAKING CAPACITY

1. Cognition

Deals with:

- a. Sensorium - consciousness and orientation,
- b. Memory - immediate retention and recall, recent memory and remote memory,
- c. Intellectual tasks - counting and calculation, judgment and insight, and abstract ability.

In this area, tests of judgment, abstract ability and insight are those most susceptible to assessor bias. The distinction between socially and medically or psychiatrically based deviations from norms must be kept in mind and the full range of human differences respected. Purely cognitive tests would in many cases allow detection of those that are globally incapable but are not finely calibrated to

⁴²² The difficulty inherent in trying to distinguish facts from opinions was discussed in *Operation Dismantle Inc. v. R.* (1985), [1985] 1 S.C.R. 441, [1985] S.C.J. No. 22 at 29-30, per Wilson J.

discriminate levels of marginal ability. We are primarily going to test those elements of decision making capacity and social function that are germane to the decision making situation in question. The problem with most of the tests, including the mental status examination, is that they address specific diagnostic (or treatment) concerns such as psychopathology or organicity which may not be directly connected with decision making ability, except in extreme circumstances where functioning is severely compromised. Hence, the clinical criteria of decision making capacity must be understood as having some elements in common with diagnostic tests but must be uniquely shaped to address directly the individual's functional abilities.

2. Thought Content

Thought content includes the presence of suspiciousness, guardedness, and paranoid ideation as well as delusions or false fixed ideas that do not seem to be in keeping with the individual's culture or reality. Delusions present one of the greatest challenges to the assessment of capacity because a fine line may be all that separates a delusion from reality. Delusions must be treated with a large measure of care and protected with extra procedural safeguards to ensure that an individual's rights are not infringed.

3. Thought Process

Thought process includes the assessment of the volume and flow of thought, its relevance, coherence, and logic, as well as the detection of a number of other factors such as the presence of blocking and neologisms. The assessment of these parameters is susceptible to coloration and bias in favour of compliance with social norms. In particular, relevance, coherence and logic are generally tested from the perspective of an individual's conformity with consensually derived perceptions of what is normal.

4. Conduct

Past conduct can be very relevant as a source of evidence of the decision maker's ability to make an acceptable choice with respect to a specific decision and is especially significant in those cases where a sudden departure from established behaviour and preference patterns corroborates a diagnosis of some medical condition and establishes a profile that is consistent with proof of incapacity.

5. Context Specific Functional Parameters

Since functional parameters tend to be context specific, these factors will be discussed in the sections setting out proposed criteria for use in tests of each of the types of capacity that have been considered by the Enquiry.

C. ELEMENTS OF DECISIONAL CAPACITY - SUMMARY

Capable decision making requires effective communication and the provision of the information required for the individual to be able to make an informed decision. The elements of decision making capacity that must be assessed include: cognition/sensorium, memory and intellectual abilities; thought content; thought process; conduct; and context specific functional parameters.

XV. PROPOSED ASSESSMENT PROTOCOL

We propose that the following four stage approach to the assessment of capacity be employed to facilitate the operationalization of the previously discussed considerations.

Threshold - When an individual's capacity is brought into question for an identifiable reason, such as an act suggestive of incapacity or the occurrence of a defined event (committal, admission to nursing home, etc.), the individual will be considered to have satisfied the threshold test and will be given the screening test. At time of admission, assessment should include the ability to make financial and treatment decisions (of a sort pertinent to circumstances) as well as the capacity to appoint a substitute decision maker.

Screening Test - This is a simple test that can be administered by a lay person who has been trained to perform this task. If passed, the individual will be treated as capable unless another party provides compelling evidence to the contrary, in which case a formal assessment may be conducted. In the event that the individual fails the screening test, he or she will then be given a formal assessment before an official finding of incapacity is made.

Formal Assessment - The formal assessment is to be conducted by an individual other than the "screener" and is comprised of two separate stages. The first reviews the potential impact of the decision. In those cases in which it is determined that no significant impact is likely to result, the assessment will be terminated and the individual's choice will prevail, as long as the individual can express a clear choice. In the event that a significant impact is likely, the assessor will then proceed to perform a full assessment. On the basis of these tests and the application of the criteria in light of the principles set out in this report, the assessor will make a determination of the individual's capacity to make the decision in question. In order to protect the autonomy of the decision maker, it will be necessary in most cases that either a Patient Advocate or some other individual acting as the decision maker's representative participate in this determination and that either the individual or his or her representative be able to trigger a review by the Review Board.

Review Board - The Review Board would apply the same criteria as are employed in the formal assessment. Its decisions may be appealed to the District Court in the manner set out in the *Mental Health Act*.

A. THRESHOLD TEST

Both practical concerns and philosophical principles require that the presumption of competency be a robust one and therefore that the threshold that must be crossed before an individual would be subjected to a full test of capacity should be a relatively high one. For this reason, it is proposed that under normal conditions,⁴²³ an individual would have to fail two levels of preliminary assessment (the first being the threshold test, the second being the screening test) before he or she would be subjected to formal assessment. For such individuals, the threshold test requires behaviour that is sufficiently deviant under the circumstances so as to call attention to the individual and raise doubts about his or her mental capacity. This determination would normally be made by a professional in a fiduciary relationship to the individual whose capacity is in question. Thus, a psychiatrist, non-psychiatric physician, psychologist, lawyer, accountant or other similarly situated professional could determine that an individual should be assessed in the screening test.

In practice we recognize that the persons who will be making the threshold assessment will not, for the most part, be trained in making capacity assessments. Therefore, it is unreasonable to expect them to be able to finely balance the considerations and factors discussed above. Assessors are likely for this reason to place undue weight on the outcome of a decision rather than properly analyze the individual's decision making processes.

The submissions received by the Enquiry remind us that individuals may be abused either by being wrongly characterized as incapable, or by being classed as capable when they are in fact incapable. Within the latter group we are particularly concerned about institutionalized incapable consenters. In order to protect this group without imposing the burden of a formal capacity assessment on everyone, it is proposed that individuals who are committed to a psychiatric hospital or admitted (for a protracted period) to a chronic care facility be automatically given the screening test to assess their capacity to consent to treatment and/or manage their estates. We note that in some situations, capacity testing would need to be performed prior to admission in order to ensure that the individual was capable of giving a valid consent to admission.

⁴²³ Normal conditions being loosely defined in terms of the absence of the possibility of coercive institutional conditions.

B. SCREENING TEST

The screening test would be administered by either a lay or professional assessor who has been specifically trained to perform this task. Unlike the threshold assessment, this test focuses on the individual's functional abilities, and places relatively little weight on the probable outcome of the decision that is in issue. The screening test, as set out below, reflects a number of parameters that have been extensively studied in the context of the Folstein Mini Mental State Exam,⁴²⁴ with the addition of some further questions which are intended to reflect the specific requirements of the decision that is at issue in a particular situation. The recommended set of questions are as follows:

Orientation

- 1) Do you know who you are, tell us your name? (1 point)
- 2) Do you know where you are? (Country, Province, Town, Address) (4 points)
- 3) Do you know what season, month and year it is? (3 points)

Registration and Short Term Memory

- 4) Name three objects, one second between each. Then ask the person to repeat the three objects after you have said them. (3 Points) Repeat the process until the individual has learnt all three, to a maximum of six times.

Attention and Calculation

- 5) Have individual count down by 7s from a number that is close to 100, if he or she is unable ask them or alternatively spell "world" backwards. (5 points)

⁴²⁴ M.F. Folstein, S.E. Folstein and P.R. McHugh "Mini-Mental State - A Practical Method for Grading the Cognitive State of Patients for the Clinician". (1975) 12 Journal of Psychiatric Research 189, see the discussion of the MMS in the previous section on neuro-psychological instruments. The use of the MMS as a screening tests, and its limits, are discussed in J.C. Anthony, U. Niaz, L.A. LeResche, M.R. VonKorff and M.F. Folstein "Limits of the 'Mini-Mental State' as a Screening Test for Dementia and Delirium Among Hospital Patients". (1982) 12 Psychological Medicine 397.

Recall

- 6) Have individual repeat the three objects again. (3 points)

Language

- 7) Repeat the following "No Ifs, Ands or Buts". (1 point)
- 8) Read and obey the following: "Close your eyes". (2 points)
- 9) Write a sentence. (1 point)

Understanding

The decision maker must be informed of the nature of the decision, the choices that are available and the advantages and disadvantages of these choices.

- 10) What is the decision you are being asked to make? (1 point)
- 11) Why do you have to make this decision and what choices do you have? (2 points)
- 12) Can you tell me the advantages and disadvantages of each choice? (4 points)

The above test is simple enough that it can be administered by lay individuals after a relatively brief period of training. The first step involves making the decision maker comfortable and making sure that there are not any communication difficulties (such as sensory or motoric difficulties) or other factors (such as social or cultural incompatibilities) which could adversely affect the individual's performance on the test. The assessment should focus on the individual's "functional" rather than "formal" abilities and in this way reflect his or her ability to operate.⁴²⁵ The assessor should endeavour to establish a rapport with

⁴²⁵ B.S. Nolan "Functional Evaluation of the Elderly in Guardianship Proceedings". (October 1984) Law, Medicine & Health Care 210 at 211 characterizes the distinction as follows:

The functional assessment differs from other sorts of evaluations and diagnostic methods primarily in its focus on **resulting behaviour**. The functional evaluator records the extent to which a subject carries out activities of daily living effectively. Thus, for example, when the defendant is disoriented as to date and time but uses newspapers and television announcements as cues to compensate for this

the decision maker and should ensure that he or she is consenting and cooperating with this assessment. During the assessment, the assessor should encourage the decision maker by administering praise, and should avoid pressing him or her with respect to questions that are proving difficult. Alternatively, the assessor should move on to the next question so as to avoid frustration and loss of cooperation. The questions should be administered in the same order as set out above and should be scored as they are answered. The instructions to be given during the administration of the test are as follows:

Orientation

- 1) Ask the individual his or her name. Mark one point if he or she gives a first and last name. (1 point)
- 2) Ask the individual the name of the institution (or address if not in an institution), then ask them the name of the town or city, the province and the country. Mark one point for each correct answer. (4 points)
- 3) Ask the individual what season, month and year it is. Mark one point for each correct answer. (3 points)

Registration and Short Term Memory

- 4) Ask the individual if you may test his or her memory. Then name three unrelated objects, slowly and clearly, about one second between each. After you have said all three, ask the decision maker to repeat them back. This test determines the score (score 1 point for each correct answer) but irrespective of score, repeat the process until the individual has learnt all three and can repeat them (up to a maximum of six times). (3 Points)

Attention and Calculation

- 5) Select a number within 10 of 100 and ask the individual to begin at that number and count backwards by 7s. (For example if 99 was the starting number the correct sequence would be 99, 92, 85, 78, 71, 64) Stop after 5 subtractions and give one point for each correct subtraction. If the individual is unwilling or unable to count down by 7s ask him or her to spell

deficit, functional evaluation would credit the adaptation as an effective use of resources. In contrast, a formal mental status evaluation would note the disorientation negatively.

the word "world" backwards. Award one point for each letter in the correct order. (5 points)

Recall

- 6) Ask the individual to repeat the three words that he or she had learned earlier. Give one point for each correct answer. (3 points)

Language

- 7) Ask the individual to repeat the phrase: "No ifs, ands or buts". If he or she repeats it correctly, award 1 point. (1 point)
- 8) Ask the individual to read and obey the following: "Close your eyes". Award one point if he or she is able to read the sentence and one point if he or she shuts his or her eyes. (2 points)
- 9) Ask the individual to write a sentence. Award one point if he or she writes a sentence that contains a verb and a subject and makes sense. Correct grammar, spelling and punctuation are not required. (1 point)

Understanding

- 10) Inform the decision maker about the nature of the decision that he or she is required to make (create a hypothetical if there is not a specific decision at issue in the assessment), the choices that are available, and the advantages and disadvantages of these choices. Ask him or her what is the decision that he or she has to make. Award one point if he or she correctly identifies the decision. (1 point)
- 11) Ask the individual why he or she has to make this decision and what choices he or she has. Award one point for a reason that he or she has to make the decision and one point if he or she identifies at least two choices. (2 points)
- 12) Ask the individual for the advantages and disadvantages of the choices. You may refresh his or her memory with respect to the choices if required. Award one point each for one advantage for each of two choices, and award one point each for one disadvantage of each of two choices. (4 points)

The following are among the claims that have been made by the authors of the MMS, and should therefore be equally applicable to the first nine questions of the above test.⁴²⁶

The MMS is a valid test of cognitive function. It separates patients with cognitive disturbance from those without such disturbance. Its scores follow the changes in cognitive state when and if patients recover. ...

... As it is a quantified assessment of cognitive state of demonstrable reliability and validity, it makes more objective what is commonly a vague and subjective impression of cognitive disability during the assessment of a patient. It can provide this quantification easily requiring only a few minutes to complete. It can be repeated during an illness and shows little practice effect. Thus it is ideal for initial and for serial measurements of this important aspect of mental functioning and can demonstrate worsening or improvement of this feature over time and with treatment.

* * *

The MMS as it is extracted from the clinical examination has an advantage in assessment of patients and clinical problems not so obvious in tests such as the WAIS that are designed for other purposes such as prediction of school or occupational performance. Thus failures in the MMS on orientation, memory, reading and writing have much clearer implications than do failures in digit symbol, picture completion or vocabulary subtests of the WAIS in terms of a patient's capacity to care for himself. These implications from the MMS score are easily appreciated by other professionals such as lawyers, judges and social workers concerned with such issues as the patient's competency to manage his daily affairs. It can therefore aid in bringing to the patient the social supports that he needs.

The MMS was studied at Johns Hopkins School of Medicine and was administered to 97 consecutively admitted patients at the Johns Hopkins Hospital. The goal of this investigation was the evaluation of the use of the MMS to assess individuals in a broader range of both diagnostic and demographic categories. In particular, it sought to include individuals who were not seeking psychiatric treatment, and those who were members of lower socioeconomic status and educational level groups. These classes of individuals had been under represented in previous studies. This study⁴²⁷ serves to confirm the usefulness of this instrument as a screening test, assists us in establishing the pass-fail level, and serves to identify some factors that should be taken into account when administering this test. The study found that the MMS was 87 per cent sensitive and 82 per cent specific in detecting dementia and delirium among hospital patients on a general medical ward. The false positive ratio was found to be 39 per cent, and it was found that

⁴²⁶ M.F. Folstein, S.E. Folstein and P.R. McHugh "Mini-Mental State - A Practical Method for Grading the Cognitive State of Patients for the Clinician". (1975) 12 *Journal of Psychiatric Research* 189 at 195.

⁴²⁷ This study was reported in J.C. Anthony, U. Niaz, L.A. LeResche, M.R. VonKorff and M.F. Folstein "Limits of the 'Mini-Mental State' as a Screening Test for Dementia and Delirium Among Hospital Patients". (1982) 12 *Psychological Medicine* 397.

all individuals in this category had less than 9 years of education and that many were over the age of 60, the false negative ratio being 5 per cent. Test-retest reliability was cited at 0.89 or better, and inter-rater reliability at 0.82 or above.

The above noted results were based on the use of a 23/24 out of 30 cut-off score and gave rise to 39.4 per cent false positive and 4.7 per cent false negative determinations, when compared to independently administered psychiatric diagnoses based on DSM-III dementia and delirium criterion and other psychiatric examinations. We have noted that according to this study, the MMS tends to give rise to a disproportionate number of false positives from among individuals who have an eighth grade or less education and therefore reducing the cut-off score to 20/21 out of 30 for this group would result in the elimination of the majority of false positives. Given the presence of the additional test for understanding, we recommend the general use of a 18/19 out of 23 cut-off on the first 9 questions and the use of a reduced 15/16 out of 23 cut-off requirement for individuals with less than a high school education. We recommend setting the cut-off for the remaining questions, the three dealing with the individual's understanding of the decision, at 4/5 out of 7 for all individuals. A failure on either part of the screening test would require that the individual undergo a formal assessment.

The screening test is designed to produce a low number (approximately 5 per cent) of false negatives on the test of cognitive impairment. This requirement, when coupled with that for actual understanding of the decision, should result in a minimal number of false negatives without producing an excessive number of false positives. The test is designed to assess memory, simple cognitive functions and the decision maker's ability to integrate information and to understand the important elements of the decision. If an individual passes this test, he or she is to be considered capable and would not be formally assessed unless the party alleging incapacity was able to show strong *prima facie* evidence of incapacity and thereby justify overriding the results of the screening test. While the requirements of a strong *prima facie* case would vary with the context, it would generally include the possibility of serious prejudice to either the physical or financial well-being of the individual were they allowed to pursue their preferred choice, in addition to compelling evidence of a lack of understanding or appreciation of the relevant factors at issue in the decision.

C. FORMAL ASSESSMENT

The first stage of the formal assessment considers the consequences of the decision. This is the test for significant impact. A decision will be considered to

have a significant impact when it puts a substantial percentage of the individual's net worth at risk in situations involving financial matters, or places the physical health of the individual at risk as a result of a treatment decision. The impact of a decision with respect to the appointment of a substitute or with respect to the disclosure of medical records would be based on the potential consequences of the decision. If this assessment finds that the decision involves no significant impact, the assessment will be ended,⁴²⁸ except in those cases where the individual is incapable of expressing a clear choice, and the individual's wishes will prevail. A large measure of uncertainty with respect to the expected outcome should be considered as evidence that the decision has no significant impact.

We recommend that the formal assessment:

- 1) take the form of a new assessment, rather than a review of the screening test;
- 2) trigger the notification of rights advice and/or a patient advocate in contexts in which such are available, and notification to the individual that he or she can contact counsel or some other trusted person;
- 3) inform the decision maker that a determination of incapacity is reviewable by the Review Board and that a second screening test may also be requested; and
- 4) result in a report that would be appended to the medical record.

We would recommend that this assessment be performed by duly qualified professionals⁴²⁹ who will have received training with respect to the performance of capacity assessments in this jurisdiction, in addition to their usual professional training.

The evolving state of the art with respect to the testing of capacity makes it both impractical and undesirable for us to attempt to definitively set out the

⁴²⁸ It should be noted, however, that this disposition of the assessment of decisional capacity does not preclude further medical testing for diagnostic purposes including the recommendation of treatment for conditions which could result in impairment of the individual's capacity.

⁴²⁹ We would envision this category as including psychiatrists, non-psychiatric physicians, and psychologists.

instruments, tests and procedures that should be applied in this regard.⁴³⁰ By necessity we rely on the competence and good faith of the professionals given the responsibility for performing these assessments to apply the most efficacious instruments, technologies and practices available to them. The guidance that we offer takes the form of general instructions as to the nature of the parameters to be assessed and the principles that should inform the assessment procedures. As in the case of the screening test, preliminary concerns include those dealing with the decision maker's ability and willingness to communicate and participate in the capacity assessment. Since a meaningful assessment requires the cooperation and consent⁴³¹ of the decision maker, all reasonable attempts to secure same, including enlisting the help of friends or relatives, should be made before undertaking an assessment. The assessor should also ensure that the decision maker has been informed, using appropriate language: of the nature of the decision; the choices open to the decision maker; and the probable outcomes of these choices before undertaking any examination of the individual's capacity with respect to this decision.

In assessing the individual's capacity, the assessor should make every effort to reduce or eliminate subjective elements from the determination. In particular, the assessor should use a consistent, structured approach in the assessment to avoid allowing his or her own expectations to inadvertently affect the outcome.⁴³²

⁴³⁰ In this regard we note in particular the research that is presently underway at the Baycrest Centre, see M. Silberfeld, W.R.C. Harvey, B.M. Dickens and R.J. Pepper-Smith "A Competency Clinic for the Elderly at Baycrest Center". (1988) *Advocates Quarterly* 23, the work that is being done at the Clarke Institute and the various projects exploring related issues in the United States.

⁴³¹ The consent sub-issue is discussed in more detail in the following section.

⁴³² For a discussion of the manner in which expectations can serve to affect assessments see R.E. Kendell "An Important Source of Bias Affecting Ratings Made by Psychiatrists". (1968) 6 *Journal of Psychiatric Research* 135 which, after noting that this factor presented a significant problem, at 140 concluded:

More important than demonstrating the existence of bias is the introduction of practical measures to reduce it. ... it is clear that bias is encouraged by the nature of the customary unstructured clinical interview, allowing as it does unlimited scope to the rater to vary the wording of his questions according to the reply he anticipates, to omit questions or introduce extra ones as he sees fit, and, by delaying rating until the end of the interview, to forget or gloss over the unexpected. These sources of error could all be eliminated if structured interviewing schedules were used, stipulating the order and wording of questions, defining criteria and ensuring that the relevant areas of psychopathology are covered evenly and uniformly.

The assessment should take into account:

relevant medical history;
appropriate medical evaluation (physical exam including diagnostic tests);
presumed etiology;
course and severity of the condition causing the impairment;
appearance and affect;
mood;
behaviour (information should be derived not only from the clinical history but also from the observations of friends, family members, etc.);
intelligence (especially abstract ability, reasoning, insight and judgment);
memory (for recent and remote events);
sensorium (consciousness and orientation);
thought content (suspiciousness, paranoid ideation, delusions, etc.);
thought process (volume and flow of thought, logic, coherence, etc.);
language ability (ability to understand through writing or speech and to express oneself orally or in writing);
awareness of current health status and/or financial status;
learning

These parameters must then be considered in light of the concerns and principles that have been discussed in the previous sections of this report to determine the individual's capacity to make the decision in question.

Two problems that are particularly difficult to assess are delusions without other apparent deficits, and frontal lobe disturbances.

Delusions are particularly important, as this diagnosis provides a potential justification for the unrestrained exercise of paternalism. In this respect, the most difficult cases are those in which the individual has no other identifiable symptom but the delusion.⁴³³ Delusions should be considered only if they materially affect the individual's ability to make the decision in question. However, to provide for appropriate protection in cases where a delusion is the only psychological deficiency detected in the individual in question, we propose that in such cases that the assessor can use the delusion as the basis of a finding of incapacity only if:

⁴³³ These concerns are exacerbated by the fact that delusions are notoriously difficult to accurately diagnose in many cases. This is apparent in the low interrater reliability in the detection of delusions, see M.B. Keller, P.W. Lavori, N.C. Andreasen, W.M. Grove *et al* "Test-Retest Reliability of Assessing Psychiatrically Ill Patients in a Multi-Center Design". (1981) 16 Journal of Psychiatric Research 213.

- 1) this determination is communicated to a Patient Advocate or other third party representing the decision maker;
- 2) the representative is fully aware of and informs the decision maker of his or her right to appeal the finding of incapacity to the Review Board; and
- 3) the decision maker and his or her representative are both informed that the diagnoses of a delusion formed the basis of a determination of incapacity.

Frontal lobe disturbances may also prove problematic. The difficulty in this respect arises because the patient may demonstrate no deficits in conventional clinical assessments but will have serious difficulties with the organization and understanding of complex information, as may be demonstrated through more sophisticated psychological examinations. The assessor at either the screening or formal assessment stage should be alerted to this possibility by information concerning the health status of the individual, i.e., recent trauma, alcoholism, encephalitis, etc. When such conditions exist, it should alert the screener and assessor to the need for a careful assessment of the functioning of the frontal lobe.

In principle, we recommend that the test of understanding and appreciation that forms the basis of the statutory definition of capacity be interpreted in light of the following. While acknowledging that it is neither possible nor desirable to totally exclude consideration of the outcome of a choice, the use of this factor must be narrowly limited to inhibit the use of capacity assessment as a means of ensuring conformity with officially sanctioned selections. In keeping with this approach, we have rejected the requirement that the decision maker be able to give "rational" or "recognizable" reasons, on the basis that it is overly discretionary. Furthermore, we believe that respect for individual's autonomy, as evidenced by the presumption of competence, should require the assessor to demonstrate that the reasons given for the decision are not relevant. We recommend the use of "relevance" as an indicator because it provides a wider scope for the expression of individual preferences than either reasonableness or rationality, and ensures that choices made for other reasons, including emotional ones, will be respected.

Should our recommendations in this respect prove unacceptable and it be decided that individuals' decisions are to be tested on a reasonableness standard, we suggest that a determination of incapacity on this basis should be made subject to the same safeguards as apply to those based on the diagnoses of a delusion. These safeguards are designed to ensure that in the event the individual disagrees with the assessment that the individual and his or her representative will be accurately and fully apprised of the basis on which the individual was found to have been incapable; the individual will have, as of right, an opportunity to be heard before the Review Board. In summary, before an individual could be determined to be incapable for lack of reasonableness, the following conditions would have to be met:

- 1) the determination would have to be communicated to a Patient Advocate or another individual representing the decision maker;
- 2) the representative would have to be fully aware of and inform the decision maker of his or her right to appeal the finding of incapacity to the Review Board; and
- 3) the decision maker and his or her representative would have to be informed that unreasonableness formed the basis of the determination of incapacity.

D. REVIEW BOARD AND THE COURTS

The Review Board and the Courts would serve a number of related roles in the determination of capacity. Firstly, they provide a form of review for those capacity assessments in which the "relevancy" standard was employed. Secondly, they provide a review for capacity decisions which are particularly susceptible to the unconstrained exercise of subjective discretion, namely those involving a determination that the individual is incapable solely because they are "delusional" or have decided "unreasonably". Thirdly, the review process would ensure that all persons found to be incapable would have access to a "fair hearing" where this determination could be challenged. Fourthly, as an appellate process, the Review Boards and courts should provide authoritative review of the implementation of professionally accepted standards and procedures and assist in the interpretation of the applicable statutory provisions. As was noted above, in light of the increasing volume of knowledge and research that is being done in this area, it is desirable to maintain a measure of flexibility with respect to structure and operation of the test of capacity. In this respect, the system of review and appeal that is set out in

the *Mental Health Act* would appear to establish a good basis for the required review/appeal system.

We recommend that the role of the review board be expanded so as to give it broader jurisdiction to deal with the determination of capacity. With respect to the determination of capacity to make financial decisions, we are concerned that the use of the courts as the primary arbiter of capacity is too costly and time consuming to be compatible with the effective recognition of the concept of marginal capacity and would therefore recommend that some consideration be given to the possible use of the review board to perform this function.⁴³⁴ Since, however, this question falls outside the mandate of the Enquiry, we feel that it must be left to be considered as one aspect of the review of the report of the Fram Committee.

E. CAPACITY TO CONSENT TO THE ASSESSMENT OF CAPACITY

The question of an individual's consent to be assessed provides a number of ethical dilemmas, the most basic being the need to assess an individual to ascertain whether or not he or she has the capacity to consent to be assessed. To overcome this difficulty, we propose that a presumption of capacity to consent to capacity assessment be recognized and if necessary, codified. This presumption would allow the decision maker to consent to medical or psychological examinations which were both non-invasive and posed no significant risk without rendering the assessor or examiner liable for performing the examination without a valid consent.

The persistent and determined refusal of individuals to consent to or cooperate with an assessment of their capacity presents another difficult situation. We would suggest that in this and related situations,⁴³⁵ the assessor would have to collect as much information as is possible and if on the basis of this information it appears to the assessor that the individual is incapable, then he or she would present this information to the Review Board for a final determination of the question. The decision maker would of course have the same standing, representation, and other rights as he or she would have at any other Review Board hearing and would be bound by the result. If, on the other hand, the

⁴³⁴ It is felt that the review board's qualifications as a quasi-judicial tribunal possessing special expertise in areas of capacity determination and the review of involuntary commitment and treatment orders could make it preferable that it also be used to perform this related function.

⁴³⁵ As for example would occur if the individual and their substitute were in conflict with respect to consenting to a particular procedure, etc.

assessor determines that the individual is capable, it would appear unnecessary in most cases to take this issue to the Review Board.

F. THE ROLE OF ADVOCACY IN THE ASSESSMENT OF CAPACITY

The role of advocacy in the mental health system in Ontario has been the subject of extensive development and study over the past few years.⁴³⁶ We support the recommendation that was made by the Fram Committee that:⁴³⁷

To ensure that legal counsel will be free to act and to preclude prejudging the issue of mental capacity, a person whose mental capacity is an issue should be deemed to have capacity to retain and instruct counsel.

This presumption is however limited to proceedings brought to determine capacity.⁴³⁸ Counsel would however be obligated to act in conformity with the applicable professional principles and guidelines that now exist and those which will be developed to govern the conduct of advocacy on behalf of incapable or doubtfully capable individuals.

We recommend the development of criteria for the determination of an individual's capacity to retain and instruct counsel in non-criminal matters. In this regard it must be noted that our recommendation that an individual be presumed capable to retain and instruct counsel applies only to proceedings concerned with the determination of an individual's capacity, and therefore that doubts about an individual's capacity to retain and instruct counsel for any other purpose or proceeding would have to be made the subject of a specific capacity determination.

G. TRAINING OF ASSESSORS OF MENTAL CAPACITY

We recommend training of the individuals who will be charged with the responsibility of making and reviewing the formal assessments. Training should also be provided for those who will perform screening tests, although the requirements in this regard would be considerably lower than those for a formal assessor. Because there are a variety of settings where assessments of capacity are being

⁴³⁶ See the Fram, Manson and O'Sullivan reports.

⁴³⁷ Final Report of the Advisory Committee on Substitute Decision Making for Mentally Incapable Persons, 1987 at 93-94.

⁴³⁸ See recommendation for further study on the subject of criteria for determining an individual's capacity to instruct counsel.

conducted, pilot studies on the implementation of the report's recommendations will need to emphasize evaluations of training methods for assessors in different types of health care facilities.

H. PROPOSED ASSESSMENT PROTOCOL - SUMMARY

We propose that a four stage approach be employed in the assessment of capacity. The four stages are:

Threshold - This stage is satisfied when an individual's competency is brought into question. Satisfying the threshold stage requires that the individual be administered the screening test.

Screening Test - Which is a simple test based on the Folstein Mini Mental State Exam and can be administered by a lay person who has been trained to perform this task. If failed, the individual will be given a formal capacity assessment.

Formal Assessment - Which is a full assessment, including a medical evaluation, a mental status examination, and other tests that are appropriate under the circumstances. The results of this assessment may be submitted to the Review Board for a reconsideration of the determination.

Review Board - Which reviews decisions and applies the same criteria as are employed in the formal assessment. The decision of the Review Board may be appealed to the district court in the manner set out in the *Mental Health Act*.

Individuals should be presumed to be capable to consent to the assessment of their capacity. Individuals who persistently refuse to cooperate with an assessment would have to be evaluated on the basis of the available information with a final determination of incapacity being made only by the Review Board. Individuals should be presumed capable to instruct counsel to act on their behalf during capacity assessment and review board hearings. Programs for the training of assessors are required and should be developed during the pilot studies on the implementation of the Enquiry's recommendations.

XVI. APPLYING THE PROPOSED ASSESSMENT PROTOCOL TO DECISIONAL CONTEXTS

This section sets out a recommended criteria and makes some brief comments on implementation of the criteria and protocol within each of the contexts identified in the Enquiry's terms of reference. To help clarify the position of the Enquiry, this section also summarizes and responds to some of the recommendations made in submissions received by the Enquiry.⁴³⁹ Although many of the concerns are framed and discussed in terms of treatment capacity, they are obviously and should be assumed to apply, where relevant, to the other contexts.

In general, we recommend that the tests of capacity be based on the definition set out in the *Mental Health Act*.⁴⁴⁰ In its general form, this test requires that in order to be considered capable, an individual must have the ability to understand the subject-matter of the decision and the alternatives, and be able to appreciate the consequences of making the decision.

A. CAPACITY TO MAKE TREATMENT DECISIONS

We recommend the integration of the competency-related laws and regulations with respect to the treatment of individuals within the general medical and mental health care systems. In this regard, the anomalies which presently exist between the *Mental Health Act* and the *Public Hospitals Act* should be eliminated and the law with respect to the treatment of minors, the specification and powers of patient's representatives, selection of substitutes, etc. should be made uniform throughout all parts of the health care system in Ontario.⁴⁴¹

The emergency or rescue provisions should continue to apply in situations that present an immediate danger to life or a vital organ. Individuals in such circumstances should be treated unless there has been a clear and capable refusal of treatment.

⁴³⁹ It must be noted that this section does not purport to provide a comprehensive review of the submissions but cites only a few of the many submissions received for representative concerns.

⁴⁴⁰ R.S.O. 1980, c.262 (as amended).

⁴⁴¹ A number of the briefs including the October 1989 submission of the Ontario Hospital Association have noted the desirability of achieving uniformity through the health care system. The OHA qualified this recommendation with the further requirement that uniformity not be adopted at the expense of function.

For further discussion, see the brief of The Clarke Institute of Psychiatry dated November, 1989.

The Recommended Criteria

We recommend that the criteria used to determine whether or not an individual has the capacity to consent to medical or psychiatric treatment be closely based on that set out in the *Mental Health Act*.⁴² The *Act* provides:

- s.1(g) "mentally competent" means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;
- s.35(1)(b) "having the ability to understand the subject matter in respect of which consent is requested" in the definition of "mentally competent" means having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed;

We support the use of criteria based on the individual's "ability" to understand and appreciate. To base the criteria on actual understanding and appreciation could result in individuals being found incapable as a result of being poorly or inadequately informed about the parameters of the decision, and not as a result of any limitations in their mental abilities. However, notwithstanding the use of this definition, we recommend that an individual's capacity be tested with respect to his or her understanding and appreciation of the parameters of the actual decision that he or she is requested to make, rather than in the abstract. For this reason, and to give effect to the materiality requirements for informed consent, it is vital that decision makers be fully instructed in light of the considerations detailed in the discussion of the treatment context earlier in this report.

The words "understand" and "appreciate" are to be interpreted in accordance with the recommendations contained in the earlier sections of this report. In this regard, the determination must respect the principles, procedural requirements and safeguards that have been described above, while facilitating assessment in accordance with the evolving state of the art.

We are not entirely satisfied with the definition of "subject matter" that is contained in s.35(1)(b) and would suggest that "having the ability to understand the subject matter in respect of which consent is requested" in the definition of

⁴² R.S.O. 1980, c.262 (as amended).

"mentally competent" be defined as: "having the ability to understand the nature of their condition⁴⁴³ for which treatment is proposed and the treatment proposed."

The term "able to appreciate the consequences of giving or withholding consent" should be defined (or merely interpreted) as meaning "able to understand that they determine whether or not the treatment will be given, able to understand the probable effects, both positive and negative, of accepting or refusing the treatment, and able to appreciate the impact that these effects would have on them."

We therefore recommend that the following criteria be employed: **In order to be considered mentally capable to make a treatment decision, an individual must have the ability:**

- 1) to understand the nature of the condition for which the treatment is proposed;
- 2) to understand the nature of the proposed treatment; and
- 3) to appreciate the consequences of giving or withholding consent.

Considerations Raised in Submissions to the Enquiry

The submissions to the Enquiry noted a number of concerns that are relevant to the assessment of capacity in the treatment context and should be considered when planning the implementation of the protocol to assess capacity.⁴⁴⁴

⁴⁴³ We prefer the use of the word "condition" to "illness" to avoid the possibility that the word "illness" be interpreted as requiring that the patient agree with the specific diagnostic label that has been applied to them. Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations. The word condition is therefore less judgmental and preferable as being less stigmatizing than the word illness. Similarly the specification that the decision maker be capable of understanding of "their" condition rather than "the" illness requires that the individual be able to understand the implications of this treatment as it pertains to them rather than in the abstract. In this way the requirement for ability to understand the nature of the condition and treatment more closely dovetails with the requirement that the decision maker be able to appreciate the consequences of making the decision.

⁴⁴⁴ For discussion, see the brief of the City of Toronto Department of Public Health, dated October, 1989.

Psychiatric Nursing Interest Group - Registered Nurses Association

The April 1989 submission from the Psychiatric Nursing Interest Group of the Registered Nurses Association of Ontario at 2-3 noted:

It takes medical effort and time to declare a person as incompetent to consent to treatment. Some doctors resist declaring a patient incompetent because this decision involves data collection, documentation of findings and observations, completion of forms, and a willingness to defend their decision to a review board. This is time-consuming work for which there is presently no compensation or rewards.

Medical resistance to declare a patient incompetent to make treatment decisions puts nurses in a difficult position, as they are often left to care for severely ill patients who refuse treatment, ...

This submission highlights the futility of implementing an assessment methodology in the absence of adequate resources. Noting the predicted shortages of institutional psychiatrists, we recommend that formal assessments be carried out by either psychiatrists, non-psychiatric physicians or psychologists⁴⁴⁵ who have been trained to perform this task and that the assessment be considered a reimbursable procedure. It is expected that the use of the screening test will help to minimize the economic impact of the funding of assessments, as this test could be administered by trained lay individuals and would conserve the use of more highly trained professionals for the formal assessments.

The submission of the Registered Nurses recommended that cognitive capacity be used as the determinant of capacity to make treatment decisions.⁴⁴⁶ This brief suggested that capacity be assessed with respect to the individual's awareness and appreciation of his or her illness, symptoms and proposed treatment.

⁴⁴⁵ As was noted previously, irrespective of the identity of the individual performing the formal assessment, a full medical checkup would have to be carried out as one element of this evaluation.

⁴⁴⁶ Psychiatric Nursing Interest Group brief at 4 defined cognitive competency as "the client's ability to know, understand, and apply information about his/her illness and treatment (or lack of treatment) to his/her given situation, with an understanding of how his/her decision will affect his/her life situation. Inherent in this definition is the client's ability to appreciate the consequences of his/her decisions."

Angela Browne

The submission of Angela Browne⁴⁷ at page 4 recommended that even when an individual had been ruled "incompetent", he or she should be allowed to participate, to the extent he or she is able, in the making of decisions unless the chosen outcome was clearly against the individual's best interests. We agree with this sentiment and would add that either minimal impact or uncertainty with respect to outcome should serve to protect the individual's decision from being overruled.

Ontario Medical Association

In their submission of May 1989, the Ontario Medical Association (OMA) expressed the view that the codification of clinical standards for competence was not a desirable aim and that it was preferable that such standards be developed in an evolutionary manner. In substance, we agree with this submission and for this reason have not attempted to set out clinical standards that will govern the formal assessment of individuals' capacity but instead have endeavoured to identify guiding principles and considerations that should be respected while testing capacity with the best available instruments, tests and technologies. However, the OMA's concerns appear to go beyond the above and in the statement that "in the clinical world with pain and suffering, virtually every patient who has some pain, fear, depression or anger, which may or may not be accompanied by cerebral dysfunction, will have some lessened ability to respond with all of the cognitive and emotional strengths that they might have had if they were not ill or suffering in some way" appears to suggest that the mental capacity of all patients should be considered suspect, a suggestion with which we strongly disagree.

The OMA submission at page 3 proposes the use of a sliding scale, based on the seriousness of the treatment, to allow "patients who wish to trust their

⁴⁷ This same brief at page 5 set a low standard for capacity to make treatment decisions in the following passage:

Since a patient is presumed to be "competent", unless proven "incompetent", effort should be made by the medical staff to explain clearly to the patient the nature of the proposed treatment, why treatment is proposed, alternatives to proposed treatment, and benefits and side effects of each. The patient should be allowed to choose what mode of treatment works best, or no treatment at all. A patient who is able to follow this discussion, and communicate some understanding should be deemed to remain "competent".

We feel that this test sets too low a standard and that both understanding and some measure of appreciation represents a more appropriate basis for the determination of capacity to make treatment decisions.

physician" to do so "if the procedure were relatively common-place and not extremely intrusive, for example, a vaccination or a surgical procedure that did not require an anaesthetic" while requiring "approval by a substitute decision maker" if "the consequences were more serious, e.g., surgery with anaesthetic." We do not adopt this form of analysis but find that a similar result flows from our recommendation that the decision maker's choice should prevail with respect to decisions having no significant impact. This result arises out of respect for individuals' autonomy and the furthering of the patient's right to self determination.

The OMA's further submission that the sliding scale principle should apply to decisions on the basis of their benefit/harm ratio is not supported in our recommendations. In this regard, the proposal that in cases with a positive benefit/harm ratio, individuals only need be capable of knowing that they trust their physician⁴⁴⁸ serves to confuse the nature of tests for capacity to make a treatment decision with the issue of appointing a substitute, and undercuts the principles of informed consent. The dangers inherent in this form of decision making by unofficial substitutes would appear to outweigh the benefits that are claimed to result.

The OMA stresses the need for quick, efficient and effective procedures for the determination of incapacity. It is our expectation that most individuals could be dealt with at the screening test stage or expeditiously by formal assessment, thus limiting the use of the review board to a relatively small group of difficult cases. It is inescapable that there is and must be a cost associated with the protection of the individual in society, the efficient and effective use of resources being the best that can be hoped for in this regard.⁴⁴⁹

Don Weitz

The May 1, 1989 submission of Don Weitz recommends that "any question about or challenge to a person's competence should be decided by a judge and jury in a court of law", this recommendation being "based upon the well established fact

⁴⁴⁸ OMA Brief at 6 sets out this test of capacity as follows:

- a patient should be able to understand and appreciate the nature of the patient-doctor relationship and have the ability to trust or say no to the physician. Since the patient-doctor relationship involves a sacred trust and a fiduciary responsibility, a physician would be held responsible for his decisions through civil law and the disciplinary colleges.

⁴⁴⁹ For further discussion, see the brief of the Ontario Hospital Association, dated November, 1989.

that competence is a social and/or legal concept and not a medical or psychiatric concept".⁴⁵⁰ We find the costs in both time and other factors that would be required in order to implement this recommendation to be unjustifiable and given the historical tendency of courts to rely on the opinions of medical experts, it would appear uncertain that this requirement would have any impact beyond those arising as a result of the increased costs.

University of Ottawa - Ottawa General Hospital

The March 29, 1989 submission of Dr. F.M. Mai of the University of Ottawa - Ottawa General Hospital reiterated the need for a simplified system for the appointment and functioning of substitute decision makers and noted the difficulties that flow from situations in which treating physicians are engaged in adversarial proceedings before the review board with respect to the capacity of their patient.⁴⁵¹ The form employed in competency assessment at Ottawa General requires the patient understand and appreciate the basis, nature, purpose, risks and benefits of the treatment and incorporate that information in responding to the recommendation.

The October 26, 1989 submission of the University of Ottawa School of Medicine points out the problem with the present practice, which tends to follow the path of least resistance, treating all consenters and failing to treat refusers whether capable or not, thus resulting in incapable refusers being left alone until their condition deteriorates to an emergency status. To respond to the problem, this brief suggests that legislation encouraging early intervention for treating medical and surgical conditions of incapable refusers needs to be drafted. We expect that the mandatory screening of all involuntary patients, when coupled with the recognition of capacity assessment as a reimburseable procedure and greater education in this respect, will change this tendency and hopefully lead to the recognition that care givers have a professional duty to consider, and when necessary, assess the capacity of both consenters and refusers.

⁴⁵⁰ For critical discussions, see the brief of the Community Mental Health Programme, dated October, 1989; the brief of Dr. C.M. Smelt, dated September, 1989; and the brief of Dr. Jerald Paquette, dated November, 1989.

⁴⁵¹ These concerns, in addition to the arguable existence of a conflict of interest, suggest that it might be wise to employ a psychiatrist or psychologist that is not a member of the treatment team to perform the assessment.

This submission also notes the conflict of interest inherent in the legal representation, at public expense, of incapable individuals before the review board or the courts. This brief suggests that many psychotic patients that are incapable of instructing counsel often appear before review boards with the result that they are denied their right to be treated in accordance with their best interests pursuant to the provisions of the *Mental Health Act*. In order to allow individuals to vindicate their rights, we believe that it is necessary that they be presumed capable to instruct counsel. This presumption is not, however, absolute but may be rebutted by clear evidence of incapacity. This brief suggests that there should be a mechanism for the independent assessment of patients' ability to instruct counsel and provision for the instruction of counsel by a public official such as the official guardian or public trustee. The difficulties inherent in the non-instructed or non-directed representation of doubtfully capable individuals was considered in the *Manson*⁴⁵² and *O'Sullivan*⁴⁵³ reports. We support the development of guidelines to help clarify the duty of counsel and advocates in such circumstances.⁴⁵⁴

Psychiatric Patient Advocate Office

The May 1989 Psychiatric Patient Advocate Office (PPAO) submission included a number of well researched and supported recommendations and was helpful to the work of the Enquiry in a number of areas.⁴⁵⁵ As might be expected, this submission highlighted the principles of self determination, dignity, liberty and justice as those that should be accorded priority and protected by the assessment of capacity.⁴⁵⁶ The submission noted that competency would not appear to pose a major problem, that only 3.8 per cent of individuals admitted to the ten provincial psychiatric hospitals over the period from April 1987 to March 1988 were determined to be mentally incapable and that of these only a small percentage (1.65 per cent of the 3.8 per cent) of these determinations were overturned at

⁴⁵² A. Manson, *Chairperson Advocacy in Psychiatric Hospitals: Evaluation of the Psychiatric Patient Advocate Office* (Toronto: Ministry of Health, 1987).

⁴⁵³ S. O'Sullivan, *Chairman You've Got A Friend - A Review of Advocacy in Ontario: Report of the Review of Advocacy for Vulnerable Adults* (Toronto: Ministry of the Attorney General, 1987).

⁴⁵⁴ For further discussion, see the brief of the University of Ottawa School of Medicine - Psychiatry, dated October, 1989.

⁴⁵⁵ In light of the broad scope of its analysis and recommendations we would recommend that this submission be reviewed by anyone interested in policy development in this area of the law.

⁴⁵⁶ In particular this submission suggested that the "*Mental Health Act* should be amended to include the right to the least restrictive and invasive treatment, in the least restrictive setting" and noted that advocacy and rights advice plays an essential role in the protection of these individual liberties.

review. The submission recommended that the test proposed by the Clark Committee⁴⁵⁷ be incorporated into the Enquiry recommendations, the test including the following elements:

- 1) Ability to understand and appreciate the physician's basis for recommending treatment.
- 2) Ability to understand and appreciate the effects of treatment, both positive and negative.
- 3) Ability to understand and appreciate the likely consequences of the absence of treatment.
- 4) Ability to incorporate the information in responding to a physician's recommendation.

With respect to the fourth element of the above test the Clark Committee identified the following three factors as being relevant:

- 1) the patient must express a considered, consistent choice over a reasonable time period to be considered competent.
- 2) a patient whose treatment choice is entirely founded on a pathological delusion that is well substantiated should be judged incompetent even when he manifests factual understanding of what is proposed.
- 3) the affective or emotional component must be considered in relation to competency determinations and "when the patient's emotional state is such as to prevent the patient from applying the information learned regarding the treatment choice, the patient should be judged incompetent by reason of this factor".

The PPAO submission recommended that the required level of capacity increase with the seriousness, intrusiveness and risks entailed in the decision. We agree with this suggestion and have endeavoured to reflect this suggestion and the following elements, which were also suggested by the PPAO, in the proposed protocol and criteria:

- 1) a behavioural and functional ability test rather than a sole diagnostic test;
- 2) limited rather than global incompetence determination;
- 3) an informed consent process specific to the decision at hand;
- 4) a requirement for a facilitative process that aids the expression of and respects the 'incompetent' individual's decision making ability and wishes; and
- 5) a requirement to document the reason for determining incompetence.

The PPAO suggested that the dilemma posed by individuals who refuse to acknowledge their illness be addressed through the following interpretation of the requirement that the patient be able to apply the information to his or her own situation:

When we say the patient must apply reasoning to his or her own situation, it is enough if the person is aware that he or she has a problem with thought, mood or personality which affects his or her ability to function in society.

⁴⁵⁷ Report of the Electro-Convulsive Therapy (E.C.T.) Review Committee, submitted to the Minister of Health 1985, quoted at page 14 of the PPAO submission.

This suggestion is compatible with our recommendation that objective evidence of incapacity be demonstrated in order for this determination to be made. The nature of psychiatry's diagnostic tools, as evidenced in the variations between the diagnoses that will be made of the same patient by different doctors, suggests that it is both unrealistic and indeed undesirable that a patient's capacity depend on his or her agreement with diagnoses about which it is reasonable to expect that professionals may differ.

The PPAO brief cited a number of studies that suggest that drug refusers may be behaving rationally in refusing treatment. Unpleasant side effects and/or lack of treatment efficacy being but two reasons that a patient may in fact have a better understanding and appreciation of consequences of consenting or refusing that the prescribing physician. This brief also summarized studies supporting the contention that there "is no evidence that treatment refusers generally are or will become more dangerous to themselves or others".⁴⁵⁸

We note that the PPAO submission provides an extensive discussion of a number of problems relating to the appointment and functioning of substitute decision makers and would recommend that these submissions be considered by the ministries that are presently reviewing the Fram Report.

Medical Directors of the Ontario Provincial Psychiatric Hospitals

The June 1988 "Guide to the Assessment of Competence to Consent to Treatment" developed by the Medical Directors of Ontario Provincial Psychiatric Hospitals (D. Dawson and R. Draper) sets out an attempt to operationalize the definition of competency that is set out in the *Mental Health Act*. At page 2 it suggests that:

"Ability to understand" is interpreted as a demonstrated ability (or inability) to understand the specific issues of concern (subject matter and consequences) rather than a measure of a broader or more abstract concept of intelligence and/or cognitive and perceptual impairment.

"Subject matter" is determined to include:

- a) the nature of the illness
- b) the treatment proposed
- c) the medical rationale for the treatment
- d) the outcome with and without the treatment

⁴⁵⁸ For further discussion, see the report by M. Menuck, B. Jones and R. Fleming of 1989.

The "Guide" set out a decision tree "in order to summarize the stages and suggest a logic for determining competence". The decision tree consists of a series of eight tests, each of which must be passed in order for an individual to be considered capable. A failure in any one stage leads to a determination that the individual is incapable. The decision points are as follows:

- 1) **Ability to communicate** (this being a necessary condition)
- 2) **Accepts they are ill** (this parameter should only be used if made subject to strict safeguards for the reasons discussed above)
- 3) **Understands nature of illness**
- 4) **Aware of treatment options**
- 5) **Understands outcome untreated**
- 6) **Understands nature/effects of treatments**
- 7) **Expresses a fixed choice**
- 8) **Choice considered rational** (for the reasons discussed above, this parameter should not be employed as a requirement. Insofar as it is felt desirable to review the reasons or rationality underlying a choice we recommend that such testing be limited to the requirement that the decision maker be able to provide relevant reasons for a decision).

Subject to the exceptions and limitations noted above, we support the inclusion of most of the tested parameters as important considerations in the determination of capacity, although we do not feel that it is appropriate for these concerns to be dealt with in a rigid, serial fashion. We recommend that all of the information be presented to the decision maker, be informally tested (with corrective feedback) to ensure that the decision maker has comprehended the material and only then that the decision maker's understanding be tested.

The College of Physicians and Surgeons of Ontario

The November 1989 submission of the Ontario College identifies six areas of neurological function that it suggests should be assessed when assessing an individual's capacity to make decisions relating to his or her own health care, these being:

- 1) **Attention** - Ability to "pay attention" underlies many other human cognitive functions and must be present in some measure in order for an individual to be found capable.
- 2) **Language** - Deficits in language, i.e., aphasia, are common following neurological disorders. Spontaneous speech, auditory comprehension, writing and reading comprehension are areas of particular relevance to the assessment of capacity.

- 3) **Memory** - Both recent and remote memory are important requirements of capable decision making. Recent memory can be assessed with a mental status exam, remote memory should be tested with reference to background of the individual.
- 4) **Visiospatial Function** - The only aspect of visiospatial function that is of relevance to the assessment of capacity is hemispatial neglect. This inability to read one side of a page may be overcome by requiring written materials be read out loud and is therefore not of crucial importance.
- 5) **Frontal Lobe Disfunction** - Deficiencies in frontal lobe function may impact planning, decisional capabilities and awareness or reflectiveness and can prove an insidious cause of incapacity. As noted previously any suspicion of such deficiency requires careful testing and assessment of both the deficit and its impact.
- 6) **Awareness** - Awareness and judgment are often difficult to assess and may be susceptible to subjective interpretation if not assessed in terms of objectively demonstrable inconsistencies and dissociations.

As noted previously, we would expect that all of the above parameters, with the possible exclusion of testing for hemispatial neglect and frontal lobe disfunction in some cases, would be among those tested in a formal assessment. These parameters, while important, should not be weighed too heavily in order to conform with our recommendation that functional abilities, including the ability to adapt to deficits, should be the most important concerns.

Canadian Psychiatric Association

In its position paper on financial and personal competence in the geriatric population⁴⁵⁹ the Canadian Psychiatric Association (CPA) recommends that:⁴⁶⁰

When asked to provide an assessment of a person regarding his/her competency to manage his/her person and/or affairs, the psychiatrist shall:

- 1) Personally examine the patient and using appropriate language within the context of the exam explain the purpose of the examination, unless to do so would be injurious to his/her health.
- 2) Collect the needed collateral information from appropriate family members, relevant professionals, and, when indicated, business and/or professional associates.
- 3) Order or review the appropriate medical investigations including, when indicated, neuropsychological testing.

⁴⁵⁹ Canadian Psychiatric Association (Prepared by M.J. MacKay, M.D.), "Financial and Personal Competence in the Elderly: The Position of the Canadian Psychiatric Association". (1989) 34 Canadian Journal of Psychiatry 829.

⁴⁶⁰ Ibid at 830.

- 4) Prepare written notes which include a detailed mental status examination, a multiaxial Axis 1-5 diagnoses and a description of the current level of functioning.
- 5) Make recommendations regarding the management of person and/or estate which would allow the patient to safely carry out his or her life with the least restrictions possible. In order to do so the psychiatrist must be familiar with applicable provincial laws.
- 6) Clearly explain to the person the conclusions and recommendations and the reasons for these and the consequences of these if this is not injurious to his or her health.
- 7) Seek a consultation for a second opinion if he/she is uncertain re: the financial and/or personal competency.

The CPA paper sets out a number of points to consider when assessing an individual's capacity to care for themselves. These concern the support structure and environment in which the individual is living and other factors bearing on the individual's ability to cope with the general demands of life. The CPA recommends that the following criteria be used to determine an individual's capacity to care for themselves:

- 1) Does the patient understand the importance of competence to care for him or herself and the reason for the examination?
- 2) Does the patient have realistic appreciation of the strengths or weaknesses with respect to this, and is he or she willing to seek help or assistance where indicated?
- 3) Has the patient in the recent past demonstrated ability to live safely in his/her environment with the resources available or to do so with additional available resources?
- 4) Does the patient continue to make reasonable decisions with respect to self care?

If the patient meets these criteria, he or she should be considered competent to care for him or herself.

We are concerned that the above criteria do not provide sufficient structure or guidance and would make respect for a patient's autonomy and independence⁴⁶¹ contingent upon a favourable exercise of the unconstrained discretion of the assessor. It is not hard to imagine that many members of the Canadian population would fail a test requiring them to "continue to make reasonable decisions with respect to self care" if such factors as smoking, drinking and dietary habits were carefully assessed in this regard. This approach does, however, serve to highlight the extent to which external factors can affect an individual's ability to function.

⁴⁶¹ For further discussion, see the brief of St. Joseph's General Hospital, dated September, 1989.

Ontario Psychiatric Association

The submission of the Ontario Psychiatric Association, after discussing a number of important issues and factors implicated in the assessment of capacity, made the following observations in conclusion:

- 1) That the present legal presumption of competence in all areas be retained unless and until it is seriously and formally questioned.
- 2) That incompetence of individuals to make decisions relevant to health care begins with respect to medical examination prior to treatment, but cannot include the examination of the competence of the patient to consent to these interventions. In this last area we must rely on the presumption of competence, even though it is later found to have been likely ill-founded.
- 3) Where a full and impartial assessment of competency is required, the treating physician would be prudent to seek a broader opinion but this does not need to be encoded in law.
- 4) Sources of information should be clearly indicated on the assessment report, and also important sources not used. Where lack of consent has excluded information from the treating physician, the validity of the findings is much more open to question.
- 5) Trial projects to test criteria for determining competency should be undertaken, covering as full a range as possible of cases before the criteria are adopted for province-wide use.

We are generally in agreement with and have made recommendations compatible with the above suggestions. With respect to the last point, we recommend that the implementation of the recommendations set out in this report be carried out in light of the experience at the Baycrest Clinic and recommend the use of pilot programs as an excellent way of operationalizing the proposed protocol.

Psychology Department - Sunnybrook Medical Centre

The May 1989 submission of the Psychology Department suggests that the assessment of competency requires evaluation of cognitive and behavioural functioning and identified the following factors as those which should be taken into account when appraising the cognitive components of competency:

- current and past medical history;
- presumed etiology, course, and severity of the illness causing the impairment in competency;
- sensory functioning (i.e., hearing and vision);

- language ability (ability to understand, either through writing or speech, and ability to express oneself, either orally or in writing);⁴⁶²
- intelligence (in particular, reasoning, insight and judgment). Some assessment of awareness of current health status and financial affairs should be included;
- memory (for both current and remote events);
- learning.

The above elements are among those which we have identified as factors that should be evaluated in the formal assessment. We note, however, that these elements should be assessed from a functional rather than an abstract or formal perspective.

This brief also suggests that registered psychologists be included as one of the disciplines authorized to assess capacity in all areas. For the reasons set out in the body of the report, we agree with this submission and therefore recommend that psychiatrists, non-psychiatric physicians or psychologists be able to perform formal assessments.

Ontario Nurses' Association

The October 1989 submission of the Ontario Nurses' Association suggests that the criteria for capacity to consent to treatment⁴⁶³ should include the following:

- 1) the ability to understand and appreciate the nature of the illness and the basis for recommending treatment;
- 2) the ability to understand and appreciate the effects of treatment - benefits, risks, discomfort;
- 3) the ability to understand and appreciate the likely consequences of giving consent;
- 4) the ability to understand and appreciate the likely consequences of withholding consent and the absence of treatment; and
- 5) the ability to incorporate the information received in responding to another recommendation.

We believe that the parameters suggested above represent an expanded description of, and are therefore compatible with, the test that we recommend be employed in assessing this form of capacity.

⁴⁶² For discussion of the importance of receiving health care services in one's mother tongue, see the brief of the Ministry of Health, French Language Health Services, dated October, 1989.

⁴⁶³ For further discussion, see the brief of The Ontario Mental Health Foundation, dated October, 1989.

Minister Responsible for Disabled Persons

The October 12, 1989 submission of the Minister and Advisory Council for Disabled Persons noted the following concerns relating to inappropriate determinations of incapacity:

Members are aware of incidence where persons with physical disabilities have been improperly declared incompetent simply because of the way their disability is manifested. For example, speech and motor activity of persons with epilepsy and cerebral palsy has been misinterpreted as symptomatic of a developmental or psychiatric disability. We would therefore urge the Enquiry to require that provision is made to ensure that persons with physical disabilities are not declared mentally incompetent on the basis of an inaccurate diagnosis.

As well, we believe that steps must be taken to ensure cultural sensitivity in the determination of competency. This applies to persons from various ethnocultural communities in Ontario as well as to persons with hearing impairments or those who are deaf. Council is concerned that children and adolescents can easily be misdiagnosed as mentally incompetent when in reality they are simply unable to understand or communicate with those responsible for determining competency.

This submission highlights the need for a preliminary assessment of ability to communicate and the requirement that efforts be made to enhance the decision maker's communications with the assessors in the manner described in the body of the report.

Canadian Institute of Public Health Inspectors

The October 17, 1989 submission of this group highlights the requirement for community support services and the need for some method of detecting geriatric persons whose living circumstances are seriously deteriorating as a result of a physical or mental incapacity.⁶⁶⁴ This brief also suggests that a "Guardian" should be appointed to assist such persons once certain minimum sanitary conditions have ceased to be met.

London Psychiatric Hospital - Adolescent Unit

The October 1989 submission on capacity to consent to treatment in adolescents suggests that "youngsters under 16 years of age have not developed the capacity to make informed decisions that are in their own best interest, when it involves such serious life long consequences as decisions around their mental health, and it would be unfair to the adolescent to not provide the support and guidance

⁶⁶⁴ For further discussion, see the brief of the Ontario Hospital Association, dated November, 1989.

necessary to them".⁴⁶⁵ While it may true in some cases that adolescents of age 14 or 15 lack capacity, our recommendation that children age 14 and over be treated in the same way as adults would not preclude this from being demonstrated and a substitute making the decision as a result. Our research clearly indicates that most children have, by age 14, achieved a level of developmental maturity that is comparable with that of most adults and is the basis of our recommendation in this respect. However, this approach by no means excludes the young person from receiving support and guidance but merely allows capable individuals age 14 and over to make the ultimate decision with respect to their own body and health care.⁴⁶⁶

Alzheimer Association of Ontario

The October 20, 1990 submission of the Alzheimer's Association supports the use of the definition of competency set out in the *Mental Health Act* and recognition of the marginal decision making capacity of individuals with Alzheimer persons. The Association is concerned that "Alzheimer persons in institutional settings are being medicated and restrained against their will and that such treatments are being given irrespective of the individual's capacity. The Association suggests, and we would agree,⁴⁶⁷ that such institutions should be made subject to the same set of safeguards as now apply to individuals treated pursuant to the *Mental Health Act*. The brief concludes with the statement that:

The Alzheimer Association of Ontario recommends that amendments be made to the legislation governing retirement homes, nursing homes, homes for the aged and chronic care hospitals such that a clinical finding of incompetency as defined in the *Mental Health Act* and consent from next-of-kin are required before an Alzheimer person may be medicated or restrained against his or her will and that this clinical finding be subject to review, at the request of the Alzheimer person, by an independent board of review.

⁴⁶⁵ For further discussion, see the brief of Brenda Ryan, dated September, 1989.

⁴⁶⁶ For further discussion, see the brief of The Ontario Psychiatric Hospitals and Hospital School Medical Staff Association, dated December, 1989; the brief of the Ontario College of Health Record Administrators, dated October, 1989; the brief of The Home Care Program for Metropolitan Toronto, dated October, 1989; the brief of the St. Catharines General Hospital, dated October, 1989; the brief of the Psychoanalytic Psychotherapists, dated September, 1989; the letter of J. Code, dated September, 1989; the letter of E. Blaine, dated February, 1989; and the letter of J. Blaine, (undated) 1989.

⁴⁶⁷ This result being a result of our recommendation that the law pertaining to capacity assessment be made universal throughout all facilities under the control of the Ministry of Health.

Citizens Commission on Human Rights

The December 6, 1989 submission regarding children and adolescents noted the failure of many pediatric psychiatrists to comply with the most elemental requirements for information disclosure when prescribing drugs such as "Ritalin" for "hyperactive" children and suggests that there should be an onus on the care giver to provide complete information in such cases. The brief suggests that in many cases the legal requirements for informed consent are not being met and furthermore that the absence of adequate information renders it impossible in many cases for patients to make a capable, informed decision. This brief suggests that a standard for the adequacy of information should be established and adhered to in order to ensure that patients are providing an "informed consent" to treatment and that the present "blanket" consent forms be replaced with forms providing more information. In recognition of the close connection between the adequacy and form of information, and an individual's apparent capacity, we recommend that the neutral and effective presentation of information be recognized as a fundamental requirement for a capable decision.

The fact that many so-called "psychiatric" conditions are in fact merely a manifestation of an undiagnosed "medical" condition was mentioned in this brief and has led the Enquiry to recommend that a medical examination be a mandatory part of a formal assessment of capacity.

B. CAPACITY TO MAKE FINANCIAL DECISIONS**The Recommended Test**

We recommend that the general test set out above be implemented in the following form: In order to be considered mentally capable to make a financial decision, an individual must have the ability:

- 1) to understand the nature of the financial decision and the choices available to him or her;
- 2) to understand his or her relationship to the parties to and/or potential beneficiaries of the transaction or transactions which give rise to the decision; and
- 3) to appreciate the consequences of making the decision.

Considerations Raised in Submissions to the Enquiry

University of Ottawa - Ottawa General Hospital

The March 29, 1989 submission of Dr. F.M. Mai of the University of Ottawa - Ottawa General Hospital included a form which identified the following questions as those which should be addressed by a physician when assessing the decision maker's capacity to manage his or her estate:

- 1) Does the patient suffer from delusions or hallucinations which specifically concern his finances?
- 2) Is the patient oriented to time, place and person?
- 3) Is the patient's memory sufficiently intact to keep track of financial transactions and decisions?
- 4) Is the patient's calculating ability sufficient to balance his accounts and pay bills?
- 5) Is the patient's judgment impaired with respect to financial decisions?
- 6) If the patient has extensive investments, is his general knowledge sufficient for him to be aware of what is happening in the financial market?

The above questions would appear to cover the primary deficits that could impair an individual's capacity to manage his or her estate. In order to deal capably with one's estate, one must be aware of external realities to a greater extent than is required to make a treatment decision. The consideration of delusions or evidence of incapacity requires, in addition to the delusion being relevant to the subject matter of the decision, that the safeguards that were discussed in the section concerning the formal assessment (above) be respected. The requirements for orientation to relevant information, memory, and calculating ability will vary, depending on the nature of the decision or decisions that are to be made. The fifth question above should be constrained in terms of specific thought process deficits that give rise to the conclusion that deficits in judgment exist. The final question needs to be conditioned in light of the individual's access and desire to obtain such knowledge. The test is one of capacity to learn, and on the basis of information, to make a decision, and not one of the individual's knowledge.

Angela Browne

The submission of Angela Browne suggests that "taking away one's right to control their own finances should be only a *last* resort", "should only last for the duration of time that the patient is *clearly* incompetent and that even when they have been declared incapable that the individual "should be allowed to participate

to the extent that they are able to ensure maximum input into their own lives".⁴⁰² This brief suggests that before a person be found incapable of managing his or her estate, it must be shown that the:

- 1) patient is demonstrating mismanagement of their personal finances to the degree that economic hardship is created for their dependents; and
- 2) such mismanagement continues despite severe consequences resulting from the patient's behaviour; and
- 3) less severe alternatives (e.g., budget counselling) have proven to be unhelpful in aiding the patient; and
- 4) the patient does not demonstrate any appreciation of the consequences of mismanagement of their finances.

We do not agree with the reference to results that is required by this set of criteria. We also note that the requirement that mismanagement must create a hardship for dependents is too subjective and at the same time it fails to stop an incapable individual from wasting his or her estate until this result has been accomplished. The suggestion that the individual be provided with some assistance with budgeting and planning with respect to his or her estate is a positive one that supports the decision maker's autonomy by providing a less restrictive alternative.

Ontario Medical Association

The Ontario Medical Association suggests that the "patient should understand and appreciate the nature and extent of his finances and the consequences of his decisions", and that the "patient should not be acting on a delusional belief". These criteria represent a concise summary of the required capacity although, unlike the test for treatment capacity, it requires actual understanding and appreciation rather than "ability".

Canadian Psychiatric Association

The position paper of the CPA has set out a number of points to be considered when assessing the financial competence of an individual, and suggests that the following criteria be used to make this determination:

- 1) Does the patient appreciate the importance of being financially competent and the reason for the examination?

⁴⁰² For further discussion, see the brief of the University of Ottawa School of Medicine-Psychiatry, dated October, 1988.

- 2) Does the patient have some realistic appreciation of his/her strengths and weaknesses in this area?
- 3) Does the patient understand the nature and extent of assets, liabilities, income and expenses?
- 4) Has the patient, in the recent past demonstrated ability to make sound reasonable decisions with respect to his/her financial affairs and can he/she be expected to do so in the foreseeable future?
- 5) Has the patient, when necessary, used the available resources appropriately and indicated some willingness to do so in the future?

The concerns previously expressed with respect to the CPA's suggested criteria for capacity to care for self are equally applicable to the above criteria.

C. CAPACITY TO SELECT A SUBSTITUTE DECISION MAKER

The Recommended Test

We recommend that the general test set out above be implemented in the following form: **In order to be considered mentally capable to appoint a substitute decision maker, an individual must have the ability:**

- 1) to understand the nature of the appointment and the duties of the substitute decision maker;
- 2) to understand his or her relationship to the proposed substitute; and
- 3) to appreciate the consequences of appointing the substitute decision maker.

Considerations Raised in Submissions to the Enquiry

Ontario Medical Association

The Ontario Medical Association May, 1989 submission suggests that the patient understand and appreciate his relationship with the substitute and the authority that has been given, that there be some logic in the choice and that it not be the product of a delusional belief.

Psychiatric Patient Advocate Office

The Psychiatric Patient Advocate Office submission of May 1989 made a number of recommendations to address problems that it has identified with the substitute decision maker provisions in the current *Mental Health Act*. Since these bear only peripherally on the criteria for capacity to appoint a substitute,⁴⁶⁹ we would hope that these suggestions are among those considered during the review of the Fram Report.⁴⁷⁰

D. CAPACITY TO MAKE DECISIONS REGARDING INFORMATION DISCLOSURE

The assessment of an individual's capacity to make decisions with respect to the review or disclosure of information requires consideration of the possible consequences of such review or disclosure. Such consideration suggests, therefore, that these decisions can be subdivided into two groups. The first concerns the disclosure of the clinical record⁴⁷¹ to the decision maker, the second concerns disclosure of the record to third parties.

In most cases, the lack of potential for a significant impact requires that a decision maker's request to have access to his record should be honoured, irrespective of his or her mental capacity. Exceptions to this general rule may be found to exist with respect to individuals who wish to see their record in order to further the development of delusionally based plans to cause harm to themselves or those who had given information concerning their behaviour, were caring for them, etc. For this reason, there should be an onus on the party wishing to inhibit the review of the record by the individual to demonstrate that serious harm to either the individual or another person is likely to occur as a result of the review, before an assessment of capacity be made for this purpose. We therefore recommend that where an individual wishes to examine his or her clinical record, the demonstration of the likelihood of serious harm to either the individual or

⁴⁶⁹ While the adequacy of the performance of the substitute would have little impact on the criteria for capacity to appoint a substitute. Serious deficiencies of this sort will tend to discourage the appointment of substitutes and therefore lead to a lowering of the standard that must be met before an individual will be considered capable to make other types of decisions.

⁴⁷⁰ For further discussion, see the brief of St. Joseph's Hospital, dated October, 1989.

⁴⁷¹ Note that where the *Mental Health Act*, R.S.O. 1980, c.262 uses the term "clinical records", the *Public Hospitals Act*, R.S.O. 1980, c.410 uses the term "medical records". We recommend that the term "clinical records" should be used in preference to "medical records" as it has a broader scope.

another person serve as the threshold that must be met before an assessment of the individual's capacity could be made.⁴⁷² Once this threshold has been passed, the test of capacity to consent to disclosure set out below would apply in the same manner as it does in cases involving disclosure to third parties.

The disclosure of the record to third parties poses a significant threat to the privacy interests of the patient. For this reason, the power to order such disclosure should only be exercised by individuals with the capacity to understand and appreciate the potential implications of this decision.⁴⁷³ We recommend that the general right to examine the clinical record, as described above, not apply to the disclosure of the record to third parties or to the copying of the record, if such was likely to result in the disclosure of the record to third parties.⁴⁷⁴

The Recommended Test

We recommend that the general test set out above be implemented in the following form: **In order to be considered mentally capable to make decisions concerning the disclosure of his or her clinical record, an individual must have the ability:**

- 1) to understand the nature of the record and the reason that disclosure is being requested;
- 2) to understand his or her relationship to the parties who are to be given access to the record; and
- 3) to appreciate the consequences of the disclosure of the record.

⁴⁷² For further discussion, see the brief of The Salvation Army Scarborough Grace General Hospital, dated October, 1989 and S. Kline "Release of Information: Mental Competency Considerations". (1989) 10 Health Law in Canada 144.

⁴⁷³ In this regard it seems somewhat anomalous that s.29a allows the patient to "examine or copy" the clinical record as it would seem likely their copying of the file could predictably give rise to its disclosure to third parties in a manner that violates the rules set out in s.29.

⁴⁷⁴ It would appear that this recommendation will require that an amendment be made to s.29a of the *Mental Health Act*.

Considerations Raised in Submissions to the Enquiry**Angela Browne**

The submission of Angela Browne suggests that patients should be deemed to be competent to examine/disclose personal records at will. This right would, however, be subject to curtailment in cases where the review determined that harm to the patient would probably result.⁴⁷⁵

Ontario Medical Association

The Ontario Medical Association submission of May 1989 distinguishes between examining and copying the clinical record. The brief noted that "almost every patient who wanted to review his record would likely be competent to access his record" and mentioned that those wishing to destroy the record or harm others are examples of exceptions. With respect to disclosure to third parties, the submission noted that there "is the potential for more adverse consequences to copying and disclosing the clinical records than simply reviewing the record" and on this basis noted that "the patient must understand and appreciate the consequences of copying and/or disclosing their records."

In substance, the recommendations of the Enquiry are essentially the same as those favoured by the OMA, the main difference arising out of the manner in which the requirement for capacity is eliminated or reduced with respect to the examination of the record by the patient.

Citizens Commission on Human Rights

The Enquiry was provided a copy of the October 10, 1989 submission to the Ministry on the subject of Health Care Information Access and Privacy legislation and is generally in agreement with its recommendations with respect to fair information practices that should apply to clinical records.

Mississauga Hospital - Child and Family Clinic

The October 10, 1989 submission of the Mississauga Hospital expresses concern that the clinical records of child patients not be made accessible to parents

⁴⁷⁵ This approach being essentially the same as that set out in s.29a of the *Mental Health Act*; for further discussion, see also the brief of the University of Ottawa School of Medicine-Psychiatry, dated October, 1989.

or guardians, as these records often contain very sensitive material pertaining to the child's perceptions of other members of their family. Noting that such disclosure could severely impair the privacy interests of the child, and the confidentiality of the communications with the care giver, we recommend that the psychiatric records of children not be disclosed to a parent or guardian unless the child agrees. Disclosure to third parties would therefore require the consent of both the child and the guardian.

E. APPLYING PROPOSED ASSESSMENT PROTOCOL - SUMMARY

The recommended criteria are similar to the "understand and appreciate" test set out in the *Mental Health Act*. The criteria have been adapted to reflect the contextual requirements of the four categories of capacity that have been considered by the Enquiry. Although criteria and a protocol have been recommended, the rapidly evolving state of the art with respect to the instruments, techniques and technologies precludes the making of specific recommendations with respect to these elements. We rely on the researchers and professionals in the field to implement the above recommendations using the best available instruments and techniques.

GLOSSARY

Assessor - the entity, whether a single person or a team, that is responsible for determining whether or not a decision maker has the requisite decision making capacity to be able to make an informed choice with respect to a specific decision.

Competency - is a global term which is ambiguous, value-laden and broadly applied across a wide spectrum of social activities to ostensibly identify the ability of an individual to achieve certain desired objectives. Because of its ambiguity and potentiality for stigmatizing it should be abandoned, we favour the term "decision making capacity" which more appropriately reflects the circumscribed nature of the abilities required to make specific decision.

Contextual Sliding Scale - a sliding scale which refers to the context of the question to be decided. This form of sliding scale refers to parameters such as the importance of the subject matter of the decision to the decision maker, but does not consider the choice that the decision maker has made.

Criteria - capabilities and other parameters that need to be enumerated in respect to each of the forms of decisional capacity in question.

Decision maker - the individual, whether a patient in a treatment context, a property holder with respect to financial matters, or any other individual whose decision making capacity is in question.

Decision making capacity - is the ability to make an informed choice with respect to a specific decision.

Efficacy - the extent to which a medical technology, when it is applied for a medical problem, is beneficial to a defined population under the most ideal conditions.

Effectiveness - the extent to which a medical technology, when it is applied for a medical problem, is beneficial to a defined population when it is used in the real world in the community.

False negative - a test result which wrongly indicates that an individual is capable of making the decision in question.

False positive - a test result which wrongly indicates that an individual is incapable of making the decision in question.

Instruments - specific bio-medical or neuropsychological tools that are used to assess the individual's capabilities with respect to the specific criteria.

Negative - a test result demonstrating that an individual is not incapable (the presumption and burden do not require an individual prove capacity but instead require the opposing party prove the contrary).

Outcome Sliding Scale - a sliding scale which refers to the choice made by the individual and more particularly to the expected outcome of that choice.

Positive - a test result demonstrating that an individual is incapable (the presumption and burden do not require that the opposing party show an individual to be incapable, thus making success in this task the positive result).

Preliminary Assessment - initial assessment of decision making capacity, made in response specific circumstances

Screening test - in the proposed assessment protocol the screening test is a relatively brief, simple test that is administered to individuals whose capacity has been brought into question by some evidence of incapacity or upon admission to specified institutions.

Self-Functioning - refers to one's ability to care for oneself. It includes measures of physical function (e.g., ability to perform tasks of daily living or self-care (bathing, feeding) and the ability to perform more complex instrumental tasks (shopping, cooking)), mental functioning (as it relates to the foregoing) and social functioning (e.g., morale, happiness, adjustment, family/social support, activity).

Sensitivity - a test's ability to separate that which is abnormal from that which is normal.

Specificity - a test's ability to identify specific conditions.

Test - refers to the implementation of a set of criteria through the application of certain instruments and procedures.

Threshold - in the proposed assessment protocol the threshold refers to the measure of evidence of incapacity that is sufficient to trigger the administration of the screening test.

True negative - a test result which correctly indicates that an individual is capable of making the decision in question.

True positive - a test result which correctly indicates that an individual is incapable of making the decision in question.

APPENDICES

I. RELEVANT STATUTORY PROVISIONS

A. CAPACITY TO MAKE DECISIONS ON TREATMENT

Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended) includes the following relevant provisions:

s.1(g) "mentally competent" means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;

s.1a(1) A person may give or refuse consent on behalf of a patient who is not mentally competent if the person has attained the age of sixteen years, is apparently mentally competent, is available and willing to give or refuse consent and is described in one of the following paragraphs: R.S.O. 1980, c.264

1. The committee of the person appointed for the patient under the *Mental Incompetency Act*.
 2. The patient's representative appointed under section 1b or 1c.
 3. The person to whom the patient is married or the person of the opposite sex with whom the patient is living outside marriage in a conjugal relationship or was living outside marriage in a conjugal relationship immediately before being admitted to the psychiatric facility, if in the case of unmarried persons they:
 - i. have cohabited for at least one year,
 - ii. are together the parents of a child, or 1986, c.4
 - iii. have together entered into a cohabitation agreement under section 53 of the *Family Law Act*, 1986.
 4. A child of the patient.
 5. A parent of the patient or a person who has lawful custody of the patient.
 6. A brother or sister of the patient.
 7. Any other next of kin of the patient.
 8. The Official Guardian.
- (2) If a person in a category in subsection (1) refuses consent on the patient's behalf, the consent of a person in a subsequent category is not valid.
- (3) If two or more persons who are described in different paragraphs of subsection (1) claim the authority to give or refuse consent on behalf of a patient, the claim of the person who is described in the paragraph occurring first in that subsection prevails.
- (4) If two or more persons who are described in the same paragraph of subsection (1) claim the authority to give or refuse consent on behalf of a patient, if they disagree about whether to give or refuse consent and if their claims would prevail over any other claims under subsection (3), the refusal prevails.
- (5) A person described in paragraph 3, 4, 5, 6 or 7 of subsection (1) may not give or refuse consent on a patient's behalf unless the person makes a statement in writing certifying,
- (a) the person's relationship to the patient;
 - (b) that the person has been in personal contact with the patient over the preceding twelve month period;
 - (c) that the person is willing to assume the responsibility for consent or refusing consent; and
 - (d) that the person is not aware of any other person described in the same paragraph or in a previous paragraph who claims the authority to give or refuse consent.

- (6) A person authorized to give or refuse consent on behalf of a patient shall do so in accordance with the wishes of the patient if the person knows that the patient expressed any such wishes when apparently mentally competent and in accordance with the best interests of the patient if the person does not know of any such wishes.
- (7) A person who seeks another person's consent on a patient's behalf is entitled to rely on the accuracy of the other person's written statement under subsection (5), unless it is not reasonable to do so.
- (8) A person seeking consent on behalf of a patient is not liable for failing to request the consent of another person entitled to give or refuse consent on behalf of the patient if, after reasonable inquiries, the person did not find the other person. 1987, c.37, s.2, part.

s.1d(1) A person who has not attained sixteen years of age is presumed to be not mentally competent to consent for the purposes of this Act.

- (2) The presumption that a person is not mentally competent is subject to a determination by the attending physician, the review board or a court, pursuant to subsection 29a (14), section 35 or 35b, that the person is mentally competent. 1987, c.37, s.2, part.

s.30n(1) An attending physician who completes a certificate of involuntary admission or a certificate of renewal shall give or transmit a notice in writing of completion and filing of the certificate to the patient who is the subject of the certificate and to the area director for the area, in accordance with the *Legal Aid Act*, in which the psychiatric facility is located. R.S.O. 1980, c.262, s.66, part.

- (1a) A physician who determines that a patient is not mentally competent to consent to treatment, to examine a clinical record or to manage his estate shall give or transmit a notice in writing of that determination to the patient and to the area director for the area, in accordance with the *Legal Aid Act*, in which the psychiatric facility is located.
- (1b) The officer in charge shall give or transmit a notice in writing of the child's right to apply to the review board under section 8a to the child and to the area director for the area, in accordance with the *Legal Aid Act*, in which the psychiatric facility is located. 1986, c.64, s.33 (28).
- (1c) The attending physician of a person who is the subject of an application for assessment under section 9 or of an order under section 26 shall give or transmit to the person written notice of the application or order.
- (1d) A physician who applies to the review board for an order authorizing the giving of specified psychiatric and other related medical treatment to a patient shall give or transmit written notice of the application to the patient and to the area director for the area, in accordance with the *Legal Aid Act*, in which the psychiatric facility is located.
- (1e) The notices specified in subsections (1), (1b) and (1c), excluding the notice to the area director, shall inform the patient or person,
 - (a) of the reasons for the detention; and
 - (b) that he or she has the right to retain and instruct counsel without delay. 1987, c.37, s.6.

- (2) A notice under subsection (1), (1a) or (1b) shall inform the patient and the area director that the patient or any person on his behalf is entitled to a hearing by the review board if the patient or the person gives or transmits to the officer in charge or to the review board notice in writing requiring a hearing and the patient or the person may so require such a hearing. R.S.O. 1980, c.262, s.66, part; 1986, c.64, s.33 (29).

s.33d(1) A party to a proceeding shall be afforded an opportunity to examine and to copy, before the hearing, any written or documentary evidence that will be produced or any report, the contents of which will be produced or any report, the contents of which will be given in evidence at the hearing. R.S.O. 1980, c.262, s.67, part.

- (2) Subject to subsections 29 (6) and (7), where a party to a proceeding is sixteen years of age or older and mentally competent, the party or the counsel or agent representing the party, or both, is entitled to examine and to copy any clinical record prepared in respect of the patient.
- (3) Subject to subsections 29 (6) and (7), where a party to a proceeding is under the age of sixteen years or is not mentally competent, the counsel or agent representing the party is entitled to examine and to copy any clinical record prepared in respect of the patient.
- (4) Nothing in subsection (3) prevents the counsel or agent representing a party described in subsection (3) from disclosing a clinical record to that party. 1986, c.64, s.33 (3f).

s.35(1) In this section and in sections 35a, 35b and 35c,

- (a) "electroconvulsive therapy" means the procedure for the treatment of certain mental disorders that induces, by electrical stimulation of the brain, a series of generalized convulsions;
- (b) "having the ability to understand the subject matter in respect of which consent is requested" in the definition of "mentally competent" means having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed; and
- (c) "psychosurgery" means any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or which inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions or to diagnose or treat intractable physical pain or epilepsy where those conditions are clearly demonstrable.

- (2) Psychiatric and other related medical treatment shall not be given to a patient,

- (a) where the patient is mentally competent, without the voluntary, informed consent of the patient;
- (b) where the patient is not mentally competent,
- (i) without the consent of a person authorized by section 1a to consent on behalf of the patient,
- (ii) unless the review board has made an order authorizing the giving of the specified psychiatric and other related medical treatment, or
- (iii) unless a physician certifies in writing that there is imminent and serious danger to the life, a limb or a vital organ of the patient requiring immediate treatment and the physician believes that delay in obtaining consent would endanger the life, a limb or a vital organ of the patient.

- (3) Subclause (2) (b) (iii) only authorizes the giving of such treatment as is necessary to preserve the life, a limb or a vital organ of the patient.

- (4) The consent to psychiatric and other related medical treatment,
- (a) of an involuntary patient; or
 - (b) of a person authorized by this Act to consent on behalf of a patient, does not include and shall not be deemed to include psychosurgery.
- (5) A person authorized to give or refuse consent on behalf of a patient shall consider the following factors to determine whether a specified psychiatric treatment and other related medical treatment are in the best interests of a patient,
- (a) whether the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
 - (b) whether the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment;
 - (c) whether the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
 - (d) whether the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c). 1987, c.37, s.11.

s.35(1) The attending physician of an involuntary patient may apply to the review board for an order authorizing the giving of specified psychiatric and other related medical treatment to the patient where the patient is not mentally competent,

- (a) if a person authorized under section 1a to consent to such treatment on the patient's behalf has refused to consent; or
 - (b) under the circumstances described in subsection 1a (4), application
- (2) The review board shall not consider an application unless it is accompanied by statements signed by the attending physician and a psychiatrist who is not a member of the medical staff of the psychiatric facility, each stating that they have examined the patient and that they are of the opinion that,
- (a) the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
 - (b) the mental condition of the patient will not improve or is not likely to improve without the specified psychiatric treatment;
 - (c) the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
 - (d) the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).
- (3) Each of the opinions in the statements described in subsection (2) shall be supported with reasons.
- (4) The review board by order may authorize the giving of the specified psychiatric and other related medical treatment if it is satisfied that,
- (a) the mental condition of the patient will be or is likely to be substantially improved by the specified psychiatric treatment;
 - (b) the mental condition of the patient will not improve or is not likely to improve without the specified psychiatric treatment;

- (c) the anticipated benefit from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and
 - (d) the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).
- (5) An order may include terms and conditions and shall specify the period of time during which it is effective.
- (6) No order of the board is or shall be deemed to be authority to perform psychosurgery or to administer electroconvulsive therapy.
- (7) The attending physician, the patient and such other persons as the review board may specify are parties to the proceedings before the review board.
- (8) Where the patient is not mentally competent,
- (a) the person authorized under section 1a to consent on the patient's behalf; or
 - (b) under the circumstances described in subsection 1a (4), all of the persons described therein, are also parties to the proceedings.
- (9) The officer in charge shall notify the Official Guardian forthwith after an application is made under this section or section 35b in respect of a patient determined to be not mentally competent to consent to psychiatric and other related medical treatment where it appears to the officer in charge that the patient will not be represented at the forthcoming hearing.
- (10) Upon receiving a notice under subsection (9), the Official Guardian shall represent the patient at the hearing of the application unless the Official Guardian is satisfied that another person will represent the patient.
- (11) Where a party appeals an order authorizing the providing of specified psychiatric and other related medical treatment or a specified course of psychiatric and other related medical treatment to a patient, the treatment or course of treatment shall not be provided pending the outcome of the appeal, unless otherwise ordered by a judge of the court appealed to.
- (12) Sections 33a, 33b, 33c, 33d, 33e and 33f apply with necessary modifications to an application under subsection (1). 1987, c.37, s.12, part.
- s.35b(1) A patient determined or presumed to be not mentally competent for the purpose of section 35 may apply in the prescribed form to the review board to inquire into whether the patient is not mentally competent.
- (2) If an application is made under subsection (1), the proposed psychiatric treatment shall not be given until the matter is determined by the review board or, where the patient appeals its decision, until the matter is finally determined, unless otherwise ordered by a judge of the court appealed to.
 - (3) Sections 33, 33a, 33b, 33c, 33d, 33e and 33f apply with necessary modifications to an application under subsection (1). 1987, c.37, s.12, part.

B. CAPACITY TO MAKE FINANCIAL DECISIONS

Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended) includes the following relevant provisions:

s.36(1) Forthwith upon the admission of a patient to a psychiatric facility, a physician shall examine the patient to determine whether or not he is competent to manage his estate.

- (2) The attending physician may examine a patient and a physician may examine an out-patient at any time to determine whether or not the patient or out-patient is competent to manage his estate.
- (3) After an examination under subsection (1) or (2), the physician or attending physician, as the case may be, shall enter his determination, together with written reasons therefor, in the clinical record prepared in respect of the patient.
- (4) A physician or attending physician who performs an examination under subsection (1) or (2) and who is of the opinion that the patient or out-patient is not competent to manage his estate shall issue a certificate of incompetence in the prescribed form and the officer in charge shall transmit the certificate to the Public Trustee.
- (5) Where circumstances are such that the Public Trustee should immediately assume management of an estate, the officer in charge or, where the officer in charge is not present in the psychiatric facility, the physician or attending physician shall notify the Public Trustee in the fastest manner possible that a certificate of incompetence has been issued.
- (6) A patient or out-patient may appoint the Public Trustee as committee of the estate of the patient or out-patient.
- (7) An appointment under subsection (6),
 - (a) is not valid unless it is signed and sealed by the patient or out-patient; and
 - (b) may be revoked by a written revocation signed and sealed by the patient or out-patient.
- (8) Where the Public Trustee is committee of the estate of a patient or out-patient at the time of his admission to or receipt in a psychiatric facility, a certificate of incompetence shall be deemed to have been issued and transmitted to the Public Trustee under subsection (4).
- (9) Subsections (1) to (8) do not apply to a patient or out-patient whose estate is under committeehip under the *Mental Incompetency Act*. R.S.O. 1980, c.262, s.36.

s.38(1) The Public Trustee is committee of the estate of a patient or out-patient and shall assume management thereof,

- (a) upon receipt of a certificate of incompetence;
 - (b) upon receipt of notice under subsection 36 (5);
 - (c) upon receipt of an appointment under subsection 36 (6); or
 - (d) upon receipt of a notice of continuance under section 41. R.S.O. 1980, c.262, s.38.
- (2) Where the donee of a power of attorney that contains a provision referred to in section 5a of the *Powers of Attorney Act* satisfies the Public Trustee of the existence of the power and notifies the Public Trustee of the donee's intention to manage all the estate by means of the

power of attorney, the committee of the Public Trustee under clauses (1) (a) and (b) is excluded or terminated.

- (3) Where the committee of the Public Trustee under clauses (1) (a) and (b) is excluded or terminated under subsection (2), the Supreme Court may, at any time upon the application of the Public Trustee, appoint him as committee of the estate of the donor of the power of attorney with all or any of the rights and powers conferred upon him by this Act with regard to the management of estates. 1983, c.75, s.1.

s.40. The attending physician may, after examining a patient or out-patient for that purpose, cancel the certificate of incompetence issued in respect of the patient or out-patient and the officer in charge shall forward a notice of cancellation in the prescribed form to the Public Trustee. R.S.O. 1980, c.262, s.40.

s.41(1) Where the Public Trustee is managing the estate of a patient or out-patient, the attending physician shall examine the patient or out-patient within twenty-one days before he is discharged from a psychiatric facility to determine whether or not he will be competent to manage his estate.

- (2) Where the attending physician is of the opinion, after the examination referred to in subsection (1), that the patient or out-patient will not, upon discharge, be competent to manage his estate, he shall issue a notice of continuance in the prescribed form and the officer in charge shall forward the notice to the Public Trustee.
- (3) The officer in charge shall transmit to the Public Trustee notice of the discharge from the psychiatric facility of a patient or an out-patient in respect of whom a certificate of incompetence is in force. R.S.O. 1980, c.262, s.41.

s.42 The Public Trustee ceases to be committee of the estate of a patient or out-patient and shall relinquish management thereof,

- (a) upon receipt of notice of cancellation of the certificate of incompetence of the patient or out-patient;
- (b) upon receipt of a revocation in writing, signed and sealed by the patient or out-patient, of an appointment referred to in subsection 36 (6); R.S.O. 1980, c.386
- (ba) upon receipt of satisfactory evidence of a power of attorney that contains the provisions referred to in sections 5 and 5a of the *Powers of Attorney Act* and the notice referred to in subsection 38 (2);
- (c) upon receipt of notice of discharge of the patient or out-patient, unless he has at that time received a notice of continuance; or
- (d) upon the expiration of six months after the discharge of the patient or out-patient, where a notice of continuance was received. R.S.O. 1980, c.262, s.42; 1983, c.75, s.2.

s.43(1) Where a certificate of incompetence or a notice of continuance has been issued, the patient or out-patient may apply in the prescribed form to the review board to inquire into whether or not the patient or out-patient is competent to manage his estate. R.S.O. 1980, c.262, s.43 (1); 1986, c.64, s.33 (59).

- (2) Except that applications may be made not more frequently than once in any six-month period, sections 33, 33a, 33b, 33c, 33d, 33e and 33f apply with necessary modifications to applications under subsection (1). R.S.O. 1980, c.262, s.43 (2); 1986, c.64, s.33 (60).

Ontario, *Mental Incompetency Act*, R.S.O. 1980, c.264 (as amended) includes the following provisions which are relevant to the subject of mental incompetency:

s.1 In this Act,

- (e) "mentally incompetent person" means a person,
 - (i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or
 - (ii) who is suffering from such a disorder of the mind, that he requires care, supervision and control for his protection and the protection of his property;
- (f) "mental incompetency" means the condition of mind of a mentally incompetent person;

s.7(1) The court upon application supported by evidence may by order declare a person a mentally incompetent person if the court is satisfied that the evidence establishes beyond reasonable doubt that he is a mentally incompetent person. R.S.O. 1980, c.264, s.7(1).

(2) The application may be made by,

- (a) the Attorney General;
- (b) any one or more of the next of kin of the alleged mentally incompetent person;
- (c) the person to whom the alleged mentally incompetent person is married;
- (d) the person of the opposite sex with whom the alleged mentally incompetent person is living in a conjugal relationship outside marriage;
- (e) a creditor; or
- (f) any other person. 1986, c.64, s.35.

(3) The alleged mentally incompetent person and any person aggrieved or affected by the order has the right to appeal therefrom.

(4) The practice and procedure on the appeal shall be the same as on an appeal from an order made by a judge of the court. R.S.O. 1980, c.264, s.7 (3,4).

s.8(1) Where in the opinion of the court the evidence does not establish beyond reasonable doubt the alleged mental incompetency, or where for any other reason the court considers it expedient so to do, instead of making an order under subsection 7 (1), the court may direct an issue to try the alleged mental incompetency.

(2) Subject to section 9, the issue shall be tried with or without a jury as the court directing it or the judge presiding at the trial may order.

(3) The trial shall take place at such time and place as the court may direct.

(4) On the trial of the issue the alleged mentally incompetent person, if within the jurisdiction of the court, shall be produced, and shall be examined at such time and in such manner, either in open court or privately, and, where the trial is with a jury, before the jury retire to consider their verdict, as the presiding judge may direct, unless the court by the order directing the issue or the judge presiding at the trial dispenses with the production of the mentally incompetent person or with his examination.

(5) On the trial of the issue the inquiry shall be confined to the question whether or not the person who is the subject of the inquiry is at the time of the inquiry a mentally incompetent person and incapable of managing himself or his affairs, and the presiding judge shall make an order in accordance with the result of the inquiry.

- (6) The practice and procedure as to the preparation, entry for trial and trial of the issue, and all the proceedings incidental thereto, shall be the same as in the case of any other issue directed by the court or a judge.
- (7) The alleged mentally incompetent person and any person aggrieved or affected thereby have the like right to move against a verdict or to appeal from an order made upon or after the trial as may be exercised by a party to an action in the court including the right of appeal, and the court hearing any such motion or appeal has the same powers as upon a motion against a verdict or an appeal from a judgment entered at or after the trial of an action.
- (8) Subject to section 11, the order or judgment of the court or, where the issue is tried by a jury, the verdict of the jury is final unless set aside upon appeal or motion under subsection (7). R.S.O. 1980, c.264, s.8.

s.9 An alleged mentally incompetent person is entitled to demand, by notice in writing to be given to the person applying for the declaration of his mental incompetency and also to be filed in the office of the clerk of the county or district court in which the proceedings have been brought, at least ten days before the first day of the sittings at which the issue is directed to be tried, that any issue directed to determine the question of his mental incompetency shall be tried with a jury, and, unless he withdraws the demand before the trial, or the court is satisfied by personal examination of the mentally incompetent person that he is not mentally competent to form and express a wish for a trial by jury and so declares by order, the issue shall be tried by a jury. R.S.O. 1980, c.264, s.9.

s.11(1) Upon application at any time after the expiration of one year from the date of the order by which a person has been declared a mentally incompetent person, or sooner by leave of the court, the court, if satisfied that the person has become mentally competent and capable of managing his own affairs, may make an order so declaring.

- (2) Any such order is subject to appeal as provided by subsections 7 (3) and (4).
- (3) Instead of making an order under subsection (1), the court may direct an issue to try the question of the recovery of the person so formerly declared or adjudged a mentally incompetent person.
- (4) Any issue so directed is subject to sections 8 and 9.
- (5) Where a person formerly declared a mentally incompetent person has been found to be mentally competent and capable of managing his own affairs and the time for appealing from or moving against the order or verdict has expired, or if an appeal is taken or a motion made, when the same has been finally dismissed, an order may be issued superseding, vacating, and setting aside the order declaring the mental incompetency of the person for all purposes except as to acts or things done in respect of the person or estate of the mentally incompetent person while the order was in force. R.S.O. 1980, c.264, s.11.

C. CAPACITY TO SELECT A SUBSTITUTE DECISION MAKER

Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended) includes the following relevant provisions:

s.1b(1) A person who has attained the age of sixteen years and is mentally competent to do so has the right to appoint a representative who has attained the age of sixteen years and is apparently mentally

competent to give or refuse consent on behalf of the person for the purpose of paragraph 2 of subsection 1a (1).

- (2) An appointment of a representative shall be made in writing in the presence of a witness.
- (3) An appointment may be subject to such conditions and restrictions, if any, as are contained in it and not inconsistent with this *Act*.
- (4) The attending physician shall inform the patient in writing of the patient's right under subsection (1) within forty-eight hours after the patient is admitted or registered to the psychiatric facility.
- (5) As soon as practicable, the officer in charge shall inform all persons who are patients of the facility at the time of the coming into force of this section in writing of their rights under subsection (1).
- (6) The notice shall be in the form prescribed by the regulations and shall inform the patient of the powers and responsibilities of a representative under this *Act*.
- (7) If a patient gives or transmits to the officer in charge a statement in writing appointing a representative, the officer in charge shall transmit the statement to the representative forthwith.
- (8) A person who has appointed a representative may revoke in writing the appointment and may appoint in writing a new representative while mentally competent to do so, and subsection (7) applies with necessary modifications in respect of the revocation and new appointment. 1987, c.37, s.2, part.

s.1c(1) A patient who has attained the age of sixteen years, is not mentally competent to appoint a representative and has not named a representative under section 1b, has the right to apply to the board for the appointment of a representative requested by the patient to give or refuse consent on behalf of the patient for the purpose of paragraph 2 of subsection 1a (1).

- (2) An attending physician who determines that a patient is not competent to appoint a representative shall as soon as practicable inform the patient in writing of the patient's right under subsection (1).
- (3) The notice shall be in the form prescribed by the regulations and shall inform the patient of the powers and responsibilities of a representative under this *Act*.
- (4) The patient, the person proposed as a representative, the person who would be authorized under subsection 1a (1) to consent on behalf of the patient if no order is made by the board under this section and such other persons as the board may specify are parties to a proceeding before the board under this section.
- (5) The board shall appoint a person as a representative for a patient only if the patient approves of the appointment and the board is satisfied that the person,
 - (a) has attained the age of sixteen years;
 - (b) is apparently mentally competent to give or refuse consent on behalf of the patient;
 - (c) consents to the appointment; and
 - (d) in the board's opinion it is in the patient's interest to appoint the person as a representative.

- (6) The board may appoint a person other than the person requested by the patient to be the patient's representative.
- (7) An appointment made by the board may be subject to such conditions and restrictions, if any, as are approved by the patient, set out in the appointment and not inconsistent with this *Act*. 1987, c.37, s.2, part.

The Ontario *Powers of Attorney Act*, R.S.O. 1980, c.386 (as amended) contains the following relevant provisions:

- 1. In this *Act*,
 - a) "attorney" means the donee of a power of attorney or where a power of attorney is given to two or more persons, whether jointly or severally or both, means any one or more of such persons;
 - b) "legal incapacity" means mental infirmity of such a nature as would, but for this *Act*, invalidate or terminate a power of attorney and "legal capacity" has a corresponding meaning. R.S.O. 1980, c.386, s.1.
- 2. A general power of attorney may be in Form 1 and is sufficient authority for the donee of the power or, where there is more than one donee, for the donees acting jointly or acting jointly and severally, as the case may be, to do on behalf of the donor anything that the donor can lawfully do by an attorney, subject to such conditions and restrictions, if any, as are contained therein. R.S.O. 1980, c.386, s.2.
- 5. A provision in a power of attorney expressly stating that it may be exercised during any subsequent legal incapacity of the donor is valid and effectual, subject to such conditions and restrictions, if any, as are contained therein and not inconsistent with this *Act*. R.S.O. 1980, c.386, s.5.
- 5a 1) Where a provision referred to in section 5 is included in a power of attorney, the power of attorney may also include a provision as set out in Form 1 expressly excluding the operation of clauses 38(1)(a) and (b) of the *Mental Health Act* in the event the donor is found not competent to manage his estate under that *Act*.
- 2) Where a power of attorney containing a provision referred to in section 5 is in effect on the day the *Powers of Attorney Amendment Act*, 1983 comes into force and the donor of the power has legal incapacity on the 1st day of January, 1984, the power of attorney shall be deemed to contain the provision referred to in subsection (1). 1983, c.74, s.1.
- 7. A power of attorney that contains a provision referred to in section 5 may be revoked by the donor at any time while he has legal capacity. R.S.O. 1980, c.386, s.7.
- 8. 1) A power of attorney that contains a provision referred to in section 5 becomes invalid and of no effect, notwithstanding such provision, where,
 - a) an order has been made declaring the donor a mentally incompetent person and upon the appointment of a committee; R.S.O. 1980, c.264.
 - b) an order has been made declaring the donor incapable of managing his affairs under section 39 of the *Mental Incompetency Act* and upon the appointment of a person having the powers of a committee;

- c) the Public Trustee becomes committee of the estate of the donor unless the power of attorney also contains the provision referred to in section 5a. R.S.O. 1980, c.386, s.8; 1983, c.74, s.2(1).
- 2) A power of attorney that contains both the provisions referred to in sections 5 and 5a becomes invalid and of no effect upon the appointment of a committee of the estate of the donor by a court. 1983, c.74, s.2(2).

D. CAPACITY TO MAKE DECISIONS REGARDING INFORMATION DISCLOSURE

Ontario, *Mental Health Act*, R.S.O. 1980, c.262 (as amended) includes the following relevant provisions⁴⁷⁶:

s.29(1) In this section and in section 29a,

- (a) "clinical record" means the clinical record compiled in a psychiatric facility in respect of a patient, and includes a part of a clinical record;
- (b) "patient" includes former patient, out-patient, former out-patient and anyone who is or has been detained in a psychiatric facility. R.S.O. 1980, c.262, s.29 (1); 1986, c.64, s.33 (18); 1987, c.37, s.4 (1).
- (2) Except as provided in subsections (3) and (5) and section 29a, no person shall disclose, transmit or examine a clinical record. R.S.O. 1980, c.262, s.29 (2); 1986, c.64, s.33 (19).
- (3) The officer in charge and the attending physician in the psychiatric facility in which a clinical record was prepared may examine the clinical record and the officer in charge may disclose or transmit the clinical record to or permit the examination of the clinical record by,
 - (a) where the patient is mentally competent, any person with the consent of the patient;
 - (b) where the patient is not mentally competent, any person with the consent of the person authorized under section 1a to consent on behalf of the patient;
 - (c) any person employed in or on the staff of the psychiatric facility for the purpose of assessing or treating or assisting in assessing or treating the patient;
 - (d) the chief executive officer of a health facility that is currently involved in the direct health care of the patient upon the written request of the chief executive officer to the officer in charge;
 - (e) with the consent of the patient or, where the patient is not mentally competent, with the consent of the person authorized under section 1a to consent on behalf of the patient or, where delay in obtaining the consent of either of them would endanger the life, a limb or a vital organ of the patient, without the consent of either of them, a person currently involved in the direct health care of the patient in a health facility;
 - (f) a person for the purpose of research, academic pursuits or the compilation of statistical data. R.S.O. 1980, c.262, s.29 (3); 1986, c.64, s.33 (20); 1987, c.37, s.4 (2-6).
- (3a) REPEALED: 1987, c.37, s.4 (7).
- (4) Where a clinical record,

⁴⁷⁶ Note that where the *Mental Health Act*, R.S.O. 1980, c.262 uses the term "clinical records", the *Public Hospitals Act*, R.S.O. 1980, c.410 uses the term "medical records".

- (a) is transmitted or copied for use outside the psychiatric facility for the purpose of research, academic pursuits or the compilation of statistical data, the officer in charge shall remove from the part of the clinical record that is transmitted or from the copy, as the case may be, the name of and any means of identifying the patient; and
 - (b) is disclosed to or examined by a person for the purpose of research, academic pursuits or the compilation of statistical data, the person shall not disclose the name of or any means of identifying the patient and shall not use or communicate the information or material in the clinical record for a purpose other than research, academic pursuits or the compilation of statistical data.
- (5) Subject to subsections (6) and (7), the officer in charge or a person designated in writing by the officer in charge shall disclose, transmit or permit the examination of a clinical record pursuant to a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act.
- (6) Where the disclosure, transmittal or examination of a clinical record is required by a subpoena, order, direction, notice or similar requirement in respect of a matter in issue or that may be in issue in a court of competent jurisdiction or under any Act and the attending physician states in writing that he is of the opinion that the disclosure, transmittal or examination of the clinical record or of a specified part of the clinical record,
- (a) is likely to result in harm to the treatment or recovery of the patient; or
 - (b) is likely to result in,
 - (i) injury to the mental condition of a third person, or
 - (ii) bodily harm to a third person, no person shall comply with the requirement with respect to the clinical record or the part of the clinical record specified by the attending physician except under an order of,
 - (c) the court before which the matter is or may be in issue; or
 - (d) where the disclosure, transmittal or examination is not required by a court, under an order of the Divisional Court, made after a hearing from which the public is excluded and that is held on notice to the attending physician.
- (7) On a hearing under subsection (6), the court or body shall consider whether or not the disclosure, transmittal or examination of the clinical record or the part of the clinical record specified by the attending physician,
- (a) is likely to result in harm to the treatment or recovery of the patient; or
 - (b) is likely to result in,
 - (i) injury to the mental condition of a third person, or
 - (ii) bodily harm to a third person, and for the purpose the court or body may examine the clinical record, and, if satisfied that such a result is likely, the court or body shall not order the disclosure, transmittal or examination unless satisfied that to do so is essential in the interests of justice.
- (8) Where a clinical record is required pursuant to subsection (5) or (6), the clerk of the court or body in which the clinical record is admitted in evidence or, if not so admitted, the person to whom the clinical record is transmitted shall return the clinical record to the officer in charge forthwith after the determination of the matter in issue in respect of which the clinical record was required. R.S.O. 1980, c.262, s.29 (4-8).
- (9) No person shall disclose in an action or proceeding in any court or before any body any knowledge or information in respect of a patient obtained in the course of assessing or treating

or assisting in assessing or treating the patient in a psychiatric facility or in the course of his employment in the psychiatric facility except,

- (a) where the patient has attained the age of sixteen years and is mentally competent, with the consent of the patient;
- (b) where the patient has not attained the age of sixteen years or is not mentally competent, with the consent of the person authorized under section 1a to consent on behalf of the patient; or
- (c) where the court or, in the case of a proceeding not before a court, the Divisional Court determines, after a hearing from which the public is excluded and that is held on notice to the patient or (where the patient has not attained the age of sixteen years or is not mentally competent) the person authorized under section 1a to consent on behalf of the patient, that the disclosure is essential in the interests of justice. R.S.O. 1980, c.262, s.29 (9); 1986, c.64, s.33 (22-24); 1987, c.37, s.4 (8, 9).

s.29a(1) A patient who is mentally competent is entitled to examine and copy at the patient's own expense the clinical record of the patient or a copy of the record. 1987, c.37, s.5 (1).

- (2) A patient seeking to examine or copy a clinical record shall make a request for it in writing to the officer in charge.
- (3) Subject to subsection (4), the officer in charge shall allow the patient to examine or copy the clinical record or a copy of it.
- (4) Within seven days after the patient makes a request to examine or copy the clinical record, the officer in charge, upon the advice of the attending physician, may apply to the review board for authority to withhold all or part of the clinical record.
- (5) An officer in charge who applies to the review board under subsection (4) shall give to the patient notice in writing of the application and the ground upon which it is based.
- (6) Within seven days after receiving an application under subsection (4), the review board shall review the clinical record in the absence of the patient and by order in writing shall direct the officer in charge to allow the patient to examine or copy the clinical record or a copy of it unless the board is of the opinion that disclosure of the clinical record is likely to result in,
 - (a) serious harm to the treatment or recovery of the patient while in treatment at the psychiatric facility; or
 - (b) serious physical harm or serious emotional harm to another person.
- (7) The patient and the attending physician may make submissions to the review board before it makes its decision.
- (8) The review board shall hear any submissions from the attending physician in the absence of the patient.
- (9) The review board may hear any submissions from the patient in the absence of the attending physician.
- (10) Where the review board is of the opinion that disclosure of a part of the clinical record is likely to have a result mentioned in clause (6) (a) or (b), the review board shall mark or separate that part and exclude it from the application of the order.

- (11) Where the review board is of the opinion that a part or all of the clinical record should not be disclosed to the patient, it shall by order in writing permit the officer in charge to not disclose the record or part and it shall specify in the order the ground under which disclosure is refused.
- (12) Sections 33, 33a, 33b, 33c, 33d, 33e and 33f and the *Statutory Powers Procedure Act* do not apply to an application under subsection (4).
- (13) A patient who is allowed to examine or copy a clinical record is entitled to,
- (a) request correction of the information in it where the patient believes there is an error or omission in it;
 - (b) require that a statement of disagreement be attached to the clinical record reflecting any correction that was requested but not made; and
 - (c) require that notice of the amendment or statement of disagreement be given to any person or organization to whom the clinical record was disclosed within the year before the amendment was requested or the statement of disagreement was required. 1986, c.64, s.33 (25), part.
- (14) A patient determined or presumed to be not mentally competent for the purpose of this section or section 29 may apply in the prescribed form to the review board to inquire into whether the patient is not mentally competent. 1986, c.64, s.33 (25), part; 1987, c.37, s.5 (2).
- (15) Sections 33, 33a, 33b, 33c, 33d, 33e and 33f apply with necessary modifications to an application under subsection (14). 1986, c.64, s.33 (25), part.
- (16) Where a patient is not mentally competent, the person authorized under section 1a to consent on behalf of the patient is entitled to examine and copy the clinical record of the patient's observation, assessment, care and treatment in a psychiatric facility or a copy of that record. 1986, c.64, s.33 (25), part; 1987, c.37, s.5 (3).
- (17) Subsections (2) to (13), both inclusive, apply with necessary modifications to the disclosure of the patient's record to the person mentioned in subsection (16). 1986, c.64, s.33 (25), part; 1987, c.37, s.5 (4).

II. WHY THIS ENQUIRY NOW?

A. Competency and Competency Determination in the Context of Recent Ontario Legal History: Why this Enquiry Now?

1. Mental Health the Historical Framework: Before the Mid-1980s

Largely by historical accident, the development of the issue of competency determination has occurred in the field of psychiatry and law. The past twenty-five years have seen significant changes in legislative attitudes to mental health law and toward the concept of competency as it pertains to those involved in the system. Because of the relatively short time span, these different attitudes continue to be represented today in some form or other in our society. Consideration of the recent legal history of mental health law therefore provides a useful framework for consideration of the diverse attitudes of society as a whole, and more specifically those who have made submissions to this Enquiry.

It is easy to overlook how much our understanding and expectations have changed regarding those perceived to be of doubtful competence over the very recent past. Consideration of the recent historical context of this Enquiry on Mental Competency conveniently begins with the case of *Barsy v. Government of Manitoba*.⁴⁷⁷ That case involved a patient in a psychiatric facility who, contrary to medical instructions, ate some food prior to treatment by electro-convulsive therapy. The convulsions caused vomiting, and Barsy suffocated on his vomit. Barsy's widow sued unsuccessfully for medical negligence. What is relevant for our purposes is the attitude of the court to the administration of the psychiatric facility, the rights of the patient, and the role of law in matters involving persons with psychiatric difficulties. The court makes the following comments preliminary to consideration of the alleged medical negligence in the case:

Dr. MacNeil further testified that on the morning of June 21, 1963, he had seen two orderlies pursuing Barsy in the ward and in the corridor and that Barsy had said "I demand to see my lawyer." Mr. Adam Deis, the ward supervisor, testified that Barsy had objected to having the treatment and had asked to see his lawyer, but had not physically resisted. It was admitted by several members of the hospital staff that many patients objected to this treatment but if the doctor in charge of treatment decided it was expedient to give it, it was given, and, if necessary, by force. Plaintiff [Barsy's widow] has not argued that Barsy's lack of consent to the treatment is a factor in her claim. It is obvious that such an institution could not function efficiently if it were held that consent by the patient was legally a condition precedent to giving prescribed treatments.⁴⁷⁸

⁴⁷⁷ *Barsy v. Government of Manitoba* (1966), 57 W.W.R. 169 (Man. Q.B.).

⁴⁷⁸ *Barsy* at pp. 171 f.

Indeed, not only was it assumed by all concerned that Barsy did not have the civil right to consent to treatment if competent to do so, but the widow phrased her claim in part on the basis that Barsy was given too much liberty prior to the administration of the treatment. She argued that Barsy ought to have been restrained prior to the treatment, to ensure that he did not eat anything. This argument was not successful:

The fact that Barsy was not put under restraint and did consume food which regurgitated and caused his death does not convict the Brandon Mental Hospital staff of negligence. I am in no position to instruct the hospital authorities how they should deal with patients such as Barsy. The only evidence before me is that their policy of not policing such patients is generally approved, and the results show that this policy does not expose the patients to serious risk.⁴⁷⁹

The attitude of the courts as recently as twenty-four years ago, as evidenced in *Barsy*, was that the law ought not meddle in the running of psychiatric facilities. The civil rights movement had not expanded to take cognizance of the rights of psychiatric patients, and the common law niceties of competent consent were understood by all parties to be inapplicable. It was assumed that doctors could be relied on to make the appropriate decisions.

Given this attitude, it is not surprising that there was no consideration of Barsy's actual competence to make the treatment decision. This criterion, which is of considerable importance today, was simply irrelevant to the view the law took at that time.

While *Barsy* is a Manitoba case, a similar attitude was implicit in the Ontario law of the early to mid-1960s. The last major revision of legislation in 1935⁴⁸⁰ had involuntary committal entirely within the control of the medical profession, and provided effectively no review of committal decisions. Similarly, release was entirely within the discretion of the superintendent of the institution.

The statute in effect in the early 1960s makes no mention of treatment rights at all, let alone access to records or substitute decision making. One can only assume that the type of regime considered in *Barsy* was in effect in this period.

That statute did consider management of the estates of patients in psychiatric facilities. The Public Trustee was *ex officio* committee of the estates of all patients except voluntary patients and "*habitués*", that is, patients admitted for

⁴⁷⁹ *Barsy* at pp. 172 f.

⁴⁸⁰ *Mental Hospitals and Schools Act*, S.O. 1935, c.39.

drug or alcohol-related problems.⁴⁸¹ Voluntary patients and *habitués* could not be placed under control of the Public Trustee absent a voluntary appointment signed by the patient. In the result, all committed patients were under the control of the Public Trustee, irrespective of their level of competence, and no other patient could be placed under the Public Trustee, no matter how incompetent. Thus, while the statute did address the need for management of patient estates during hospitalization, it did not address the competency question in any way.

The sixties were a period of rapid growth and development in mental health. The discovery of neuroleptic medication had created a new range of treatment possibilities for mental illness. As hospitalization durations became shorter, a movement for community mental health services commenced. The Mental Health Services branch of the Ministry of Health was established in 1966. Psychiatry was surrounded by a glow of optimism and a renewed public image of respectability. The new attitudes led to a piecemeal modification of the *Mental Hospitals Act* and its eventual replacement by a new *Mental Health Act* in 1967.⁴⁸² The optimism about mental health care that was a feature of that period was evident in both the *Act* and the speeches accompanying its introduction.⁴⁸³ It is worth noting, however,

⁴⁸¹ Prior to 1960, the Public Trustee assumed control of estates of voluntary patients and *habitués* after three months confinement: see *Mental Hospitals Act* R.S.O. 1950, c.229, s.69. This section was amended by *Mental Health Act* S.O. 1960, c.67, s.7.

⁴⁸² *Mental Health Act* S.O. 1967, c.51.

⁴⁸³ For example in his speech introducing the new legislation the then Minister of Health, the Honourable M.B. Dymond noted that:

Mental health legislation has traditionally been of a permissive and passive character, giving sanction to the establishment of psychiatric services. Reflecting the advances that have been made in the care and treatment of the mentally disordered, The *Mental Health Act*, 1967, will give positive direction and support to the further development of the provincial mental health programme. ... [The statute] will further stimulate and support the continuing growth and development of an integrated and balanced system of comprehensive mental health services in our larger population centres. ... In the end result, every area of Ontario will be capable of offering and providing all of those services which are considered essential.

It is not sufficient merely to make exemplary services available. Those services must be readily accessible and attractive to those who need them. Under the new *Act*, admission procedures are streamlined, and treatment of mental disorder will, wherever possible, be on a basis parallel to that for physical illness. Informal admissions, which were introduced by an amendment to the *Mental Hospitals Act* in 1965, will be encouraged when hospitalization is required. [Ontario, Legislative Assembly, *Debates*, at 3638 (19 May 1967)].

that although the comments surrounding this "social legislation" suggest the provision of a benefit to people in need, the *Act* itself was largely silent on treatment issues.⁴⁸⁴ It was presumably assumed that persons in need would want the treatments proposed, or else in line with *Barsy*, that their views on the matter did not warrant consideration. Similarly, rights to view the clinical record and to appoint a substitute decision maker were not recognized in any way.

In support of individual rights the *Act*, for the first time, required the attending physician to determine whether or not in-patients were competent to manage their estates.⁴⁸⁵ This *Act* also separated the basis of civil committal from the need for treatment. Persons could be committed only if they suffered "from a mental disorder of a nature or degree so as to require hospitalization in the interests of [their] own safety or the safety of others".⁴⁸⁶ Previously, patients could be committed if two medical practitioners found them to be "mentally ill or mentally defective".⁴⁸⁷ In addition, the 1967 *Act* introduced certain due process safeguards: periodic re-assessments by the attending physician were required;⁴⁸⁸ and for the first time, the patient was given the right to challenge his or her committal before a review board.⁴⁸⁹ The finding of incompetence to manage the estate was also subject to review by the review board.⁴⁹⁰ The 1967 *Act* can therefore be seen

The only significant debate of the bill was by the New Democratic Party, which concluded the debate with the following comment of Stephen Lewis, M.P.P.:

Mr. Chairman, just before 64 is carried, may I in a moment of unaccustomed amity on behalf of this party commend the Minister on a first-rate piece of social legislation? I hope this *Act* has a good life in its implementation. [Ontario, *Legislative Assembly, Debates* at 4580 (15 June 1967)].

⁴⁸⁴ Section 26 provides that the patient will be discharged when no longer in need of "the observation, care and treatment" provided in the facility, and section 23 permits transfers for treatment to public hospitals. The one section which specifically authorizes treatment is section 14(3) of the *Act*, which allows a judge to make an order for treatment of an accused in a psychiatric facility.

⁴⁸⁵ See section 32.

⁴⁸⁶ See section 8(1)(a).

⁴⁸⁷ *Mental Hospitals Act*, R.S.O. 1960, c.236, s.23.

⁴⁸⁸ See section 13.

⁴⁸⁹ See section 28.

⁴⁹⁰ Section 39.

as a transitional piece of legislation. While reflecting the optimism of the 1960s in its view of mental health, it also began to take account of the rights of the patient.

By the 1970s, attitudes were changing and the optimism of the 1960s was wearing thin. Government funding of community alternatives was insufficient and re-admission rates to psychiatric facilities were significant. Tardive dyskinesia and other severe adverse effects of psychotropic medication were discovered. Radicals were casting doubt on the most basic premises of psychiatric medicine. Thomas Szasz, for example, published a critique of psychiatry in 1974 entitled *The Myth of Mental Illness*.⁴⁹¹ Patient advocacy and patient self-help groups had been established and were lobbying for stronger patient rights legislation. Human rights commissions were recommending inclusion of "mental disability" in the classes protected from discrimination in human rights legislation. It was in this context that the 1978 amendments to the *Mental Health Act* were formulated.

Unlike the 1967 *Act*, the amendments in 1978 were hotly debated in the legislature. The debate centred largely around the revised committal criteria, whereby the previous standard of the safety of the patient or the safety of others was given a more precise definition. Some due process provisions were made, although the bulk of these were not proclaimed until 1984. In considering the historical development, it is important to note that the 1978 *Act* for the first time recognized that patients had certain rights with respect to treatment and file release.

The provisions on both these topics were complex. In essence, the physician was given discretion to disclose the clinical record to a competent patient who had reached the age of majority. Standards were established as to when the patient's clinical record could be released to third parties, and competent patients were given a role in this process.⁴⁹² The inclusion of these provisions for the first time explicitly acknowledged the patient's interest in clinical records. Concerning the patient's right to see the information, it did not essentially vary the *status quo*, however; it was no doubt within the discretion of staff of the psychiatric facility to allow patients access to their clinical records prior to the 1978 provisions. The *Act* did not provide any mechanism to challenge a physician's refusal to allow a patient access to his or her clinical record. The thrust of the provisions in fact primarily addressed disclosure of the clinical record to third parties. The records section of

⁴⁹¹ T. Szasz *The Myth of Mental Illness* (New York: Harper and Row, 1974).

⁴⁹² *Mental Health Act* R.S.O. 1980, c.262, s.29.

the 1978 *Act* is less indicative of the rise of patient rights than of a burgeoning concern about confidentiality of health records as a whole.⁴⁹³

Competent involuntary patients were given the right to refuse treatment, although such a refusal was subject to override by the review board.⁴⁹⁴ A list of substitute decision makers was introduced for involuntary patients who were not competent to make treatment decisions.⁴⁹⁵ This was the first time in Ontario law that such a process of substitute decision making had been formalized in a statute.

The 1978 *Act* did not explicitly discuss the rights of informal patients regarding treatment. A strong argument would have been available that the *Act* pre-supposed the right of a competent informal patient to refuse treatment, however. The provisions of the *Act* can be characterized as a qualification for involuntary patients of the common law right of a competent patient to refuse treatment. If such a right were said to exist for involuntary patients, albeit in such a qualified form, it would presumably have to exist for informal patients, as it would not be logical to have a more restrictive regime for informal patients than involuntary patients. Although this argument was never actually tested in an Ontario court, it became more compelling as courts re-affirmed in cases such as *Hopp v. Lepp*,⁴⁹⁶ the essential common law rule that treatment could not legally be performed absent voluntary, informed consent. With the eventual enactment of the *Charter of Rights and Freedoms*, it was fair to assume that informal competent patients had acquired the legal right to refuse treatment, and the legacy of *Barsy* had been laid to rest, at least at law.

The social re-evaluation of legal rights of persons with mental disabilities continued. In 1980, the Ontario Human Rights Code was amended to include "handicap" among the classes protected from discrimination. With the enactment of the *Charter* in 1982, persons who were "detained", including persons civilly committed, received the constitutional right to counsel.⁴⁹⁷ Further, all state-

⁴⁹³ This concern continued in Ontario with the publication of the *Report of the Commission of Inquiry into the Confidentiality of Health Information* (Toronto: Queen's Printer, 1980) (Commissioner: The Honourable Mr. Justice Horace Krever).

⁴⁹⁴ Section 35.

⁴⁹⁵ Sections 1(j), 35.

⁴⁹⁶ *Hopp v. Lepp* [1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67.

⁴⁹⁷ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982 U.K., c.11, section 10(b).

sanctioned violations of security of the person were constitutionally valid only if in accordance with the principles of fundamental justice.⁴⁹⁸ With the decision in *Morgentaler, Smoling and Scott v. The Queen*,⁴⁹⁹ it was settled that state intrusion into medical procedures constituted a *prima facie* violation of security of the person, and therefore may only be effected in accordance with the principles of fundamental justice. That case, and others, furthermore, have held that section 7 of the *Charter* guarantees more than just procedural fairness and that the protection afforded by the "principles of fundamental justice" extends to allow the courts to override certain substantive legal provisions.⁵⁰⁰

The enactment of these *Charter* provisions provided the impetus for the proclamation in 1984 of the due process provisions related to review board hearings contained in the 1978 *Act*. Patients received an unrestricted right to view any document which would be placed before the review board.⁵⁰¹ Review board hearings became increasingly formal, and the terms of the patient-physician relationship were increasingly subject to challenge by either party before the administrative tribunal. A system of patient advocates was introduced in Ontario psychiatric hospitals at that time. The system was expanded in 1985 to include "rights advisors", who ensured that patients were aware of the decisions regarding committal, treatment, and competency which were made about them, and about the procedures for review of those decisions. The rights advisor will also assist the patient to apply for legal aid and obtain counsel, at the request of the patient. The rights advisor programme is in place in both provincial psychiatric hospitals and psychiatric wards of public hospitals.

2. Competency and Mental Health Prior to the mid-1980s

Issues of competency were not unknown under the pre-*Charter* legislative framework. The *Mental Hospitals Act*, in effect in the early 1960s, is one example of a statute that recognized the notion of competency, as is evident from the section regarding admission of voluntary patients:

⁴⁹⁸ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982 U.K., c.11, section 7.

⁴⁹⁹ *Morgentaler, Smoling and Scott v. The Queen* (1988), 37 C.C.C. (3d) 449 (S.C.C.).

⁵⁰⁰ This was authoritatively decided by the Supreme Court of Canada in *Re B.C. Motor Vehicle*, [1985] 2 S.C.R. 486.

⁵⁰¹ This right, however, was recognized earlier by the Ontario Court of Appeal decision in *Re: Abel and Advisory Review Board* (1980), 56 C.C.C. (3d) 153 which imposed a duty to act fairly on the Advisory Review Board.

- 21 (1) The superintendent of an institution may receive and detain therein as a patient any person suitable for care and treatment who voluntarily makes written application in the prescribed form and whose mental condition, in the opinion of the superintendent, is such as to render him competent to make application.⁵⁰²

There were no explicit criteria nor procedures contained in that *Act* to determine competency, and the provision was not contained in the 1967 *Act*.

The 1967 statute was concerned with competence only as it related to management of the estate. To this end, all patients in psychiatric facilities would be examined upon admission, and re-examined as the attending physician saw fit.⁵⁰³ The Public Trustee was appointed committee of the estates of persons found incompetent. The patient had the right to challenge this finding before the review board annually.⁵⁰⁴ This system became available, although not mandatory, for out-patients under the 1978 amendments,⁵⁰⁵ at which time the patient's right to challenge the finding before the review board also increased to once every six months.⁵⁰⁶ Otherwise, the system of examination and review has remained largely unchanged since 1967.⁵⁰⁷

The *Act* contained no definition of competency to manage one's estate, and indeed continues to offer no statutory guideline as to the meaning of that phrase.⁵⁰⁸ The *Mental Health Act* jurisprudence before both the review boards and the courts has offered little assistance in this respect.

The 1978 amendments to the *Mental Health Act* introduced competency as a factor in issues relating to file release and the treatment of involuntary patients. The *Act* further provided the following definition of "mentally competent":

⁵⁰² R.S.O. 1960, c.236, s.21(1). Emphasis added.

⁵⁰³ S.O. 1967, c.51, s.32.

⁵⁰⁴ s.39.

⁵⁰⁵ See *Mental Health Act* R.S.O. 1980, c.262, s.36(2).

⁵⁰⁶ s.43(2).

⁵⁰⁷ Although note the effect of amendments to the law regarding powers of attorney, discussed further below.

⁵⁰⁸ Note that the phrase used in the present *Mental Health Act* is whether a patient is "competent to manage his estate": see for example R.S.O. 1980, c.262 as amended, s.36. This ought not be confused with "mentally competent" as defined in section 1(g). Not only is the phrase different, but the definition deals specifically with issues surrounding consent, and thus has no direct application to estate management issues.

1(g) "mentally competent" means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;

The *Act*, however, did not provide a method for determining mental competency. Some argued that, as the law presumed competence and that as there were no procedures for competency determination contained in the *Act*, legal incompetency within the meaning of the statute could only be the result of an application to court under the ancient *parens patriae* power, or pursuant to the *Mental Incompetency Act*.⁵⁰⁹ The universal practice, however, was for the attending physician to make the determination of mental competency. While this custom offered the only practical solution, there were perceived problems. It is not clear that the legislation had been adequately explained to those administering it, and advocates for patients commonly found that the competency determination was conflated with the need for administration of treatment. No one was entirely clear what the definition meant in any event. Patient rights groups and advocates for patients complained that usually, competence meant agreement with the attending physician. These issues were only complicated in the context of the release of the clinical record, where the rights of even a competent patient remained at best unclear, as the relevant section of the *Mental Health Act* provided on its face an unlimited discretion on the part of the attending physician as to whether the record would be released.

As the patient bar developed in the early 1980s, these issues became increasingly topical. The existing system, silent on the issue of competency determination, could no longer provide a meaningful forum for the expression of the debate.

3. The Mid-1980s: The Charter of Rights and Freedoms and Related Legislation

The 1978 *Act* was not problem-free. The difficulty that there was no mechanism for competency determination has already been mentioned. In addition, patient rights and civil libertarian organizations objected to the fact that the wishes of a competent involuntary patient could still be overridden by the review board, and treatment administered notwithstanding the patient's competent refusal of

⁵⁰⁹ *Mental Incompetency Act* R.S.O. 1960, c.264. This argument was fortified by the decisions of some courts in the United States, which considered competency determination to be a judicial function: see, for example, *Rogers v. Commissioner of Department of Mental Health*, 458 N.E. 2d 308 (1983).

treatment. When the non-discrimination sections of the *Charter of Rights and Freedoms* came into effect in 1985, these and other issues were brought to a head.

The initial arena for public debate was the *Equality Rights Statute Law Amendment Act, 1986*.⁵¹⁰ This was Ontario's attempt to bring its statutes into conformity with the non-discrimination provisions of the *Charter*. Issues surrounding mental health law were largely unaddressed in the original draft of the legislation, notwithstanding the *Charter's* guarantee of freedom from discrimination on the basis of mental disability. Mental health issues were introduced by private members, however, and became one of the major foci of debate. The eventual statute removed the power of the review board to override the refusal of treatment by a competent involuntary patient, and provided a right of access to the clinical record to the competent patient. The review board was given jurisdiction to review the finding of an attending physician as to whether a patient was competent to gain access to the clinical record, and whether an involuntary patient was competent to consent to treatment. The *Act* made no substantial change to treatment provisions regarding informal (re-named 'voluntary' to reflect existing usage in the profession) patients.⁵¹¹ Numerous other complex procedural provisions, particularly concerning the status of patients pending review board hearings and appeals, were added to the *Act*.

The 1986 amendments to the *Act* were a rush job. The amendments were introduced by the New Democratic Party and supported by the Liberals, and thus passed in the situation of minority government. They had not been subjected to full analysis by government lawyers, and many of the new procedural issues were almost universally agreed to be unpalatable or unworkable. Some segments of the community, particularly the medical community, felt that they had not been adequately consulted prior to the enactment of the 1986 bill. Predictably under the circumstances, another bill was introduced in 1987.

The *Mental Health Act Amendment Act*⁵¹² also had a tumultuous history. The legislation, as originally introduced, did not significantly alter the mechanisms regarding review of competency. It did allow for treatment of an incompetent

⁵¹⁰ *Equality Rights Statute Law Amendment Act* S.O. 1986, c.64, s.33.

⁵¹¹ The term 'informal patient' was maintained to refer to persons such as children, who were detained in psychiatric facilities under an authority outside the *Mental Health Act*: see R.S.O. 1980, c.262, s.1(ba), as amended by S.O. 1987, c.37.

⁵¹² *Mental Health Act Amendment Act* S.O. 1987, c.37.

voluntary patient on the consent of a substitute decision maker. The review board would again have received jurisdiction to override the competent wishes of an involuntary patient regarding treatment, and a fresh set of complicated procedural provisions regarding status pending review board hearings and appeals were introduced. Finally, and significantly for our purposes, persons competent to do so were given the power to select an individual to make decisions for them in the event that they ceased to be competent to make decisions regarding treatment or file release.

Once again, it became clear that there would be no consensus as to the terms of the new *Act*. Various professional organizations and service providers, organizations representing the families of persons with mental health problems, and patient rights groups all made submissions as to the merits of the proposed legislation. Feelings ran deep. The legislation as enacted differed in a number of respects from the original bill.

The 1987 *Act* represents the law as we have inherited it. Essentially, there is no longer a distinction between competent voluntary and competent involuntary patients regarding treatment rights, file access rights, appointment of substitute decision makers, or competency to manage an estate. Competent patients have an absolute right to consent to or refuse treatment,⁵¹³ and a somewhat qualified right to view their clinical record or release it to a third party. These decisions are made by a substitute decision maker (called in the *Act* a 'patient representative') in the event that the patient is incompetent, although the refusal of treatment by a patient representative of an incompetent, involuntary patient is subject to override by the review board in prescribed circumstances.⁵¹⁴ The patient representative is to decide according to the patient's wishes expressed during periods of competency, if such wishes are known, and otherwise, in the patient's best interests. For treatment matters, a specific list of criteria is to be followed in ascertaining the patient's best interests.⁵¹⁵ Competent persons may appoint a patient representative of their choice. The provisions regarding competence to manage an estate are unchanged since 1978, and largely unchanged since 1967.

⁵¹³ The *Act* refers only to "psychiatric and related medical treatment". The common law provisions presumably apply to other medical treatment of a patient in a psychiatric facility. Thus the competent patient has the right to consent to or refuse such treatment, but the provisions of the *Act* for treatment by substitute decision makers have no application.

⁵¹⁴ At the time of writing, this was the subject of a challenge under sections 7 and 15 of the *Charter*.

⁵¹⁵ Section 35(5).

The findings of incompetence are legally distinct, and there is no legal inconsistency, for example, in a person being incompetent to manage his or her estate and competent to consent to treatment, or *vice versa*.

The 1978 definition of "mentally competent" has remained unchanged, although it is further defined regarding treatment by section 35(1)(b) of the *Act*. As noted above, it does not apply to competency to manage the estate, which remains a concept undefined in the statute. Its application to matters of competency to appoint a patient representative and applications to see one's clinical record is problematic, as the phrasing of the definition in terms of situations where the individual is required to consent does not apply directly to these situations.

The attending physician now clearly determines competence to consent to treatment, to manage the estate, and for matters regarding access to the clinical record. All of these determinations are reviewable before the review board. However, with the exception of competence to manage the estate, the *Act* is silent as to when determinations ought to occur -- what is the triggering event? The *Act* is also unclear as to who is to make the determination of competence to appoint a patient representative. As the *Act* allows persons who are not patients to make these appointments, the person making the determination can be other than an attending physician.

The effect of the present law is to make determination of competence in the various contexts an essential preliminary decision for staff of psychiatric facilities. For example, should a physician incorrectly find a patient incompetent and treat the patient on the consent of a patient representative, the physician would be liable in battery, as the patient representative has the legal authority to make the decision only if the patient is in fact incompetent. The present system of due process before the review boards is an important protection from such lawsuits for the physician. The fact that the physician's determination of competence is now directly reviewable by the review board, however, has rendered that decision much more significant on a practical legal level than under prior legislation.

As we have seen, it is only recently that the rights of psychiatric patients to consent to treatment, to appoint substitute decision makers, and to view their clinical records have even been recognized as issues. Issues surrounding competency have even more recently become recognized as central. As a result, an informed dialogue in Ontario as to the meaning of competence is in its infancy. Although some service-providing professions are beginning to develop curricula in

this area, it will be years before it can be developed and persons so trained make an impact. The Enquiry has been appointed to provide guidelines to service providers now practising in the system. As the Enquiry and the Advisory Panel have become increasingly aware, there are no easy answers to these questions. These are matters of law, ethics, and clinical judgment. Practitioners of all sorts, be they medical, social science, philosophical or legal in orientation, lack a complete framework to consider these matters.

B. Issues Relating to the Broader Population

It is largely a matter of historical accident that the debate on issues of mental competency has arisen in the context of psychiatric facilities. The Enquiry has been made aware of a huge set of problems largely unaddressed by legislation in the context of the broader community. We have been told that there are 30,000 people in extended care facilities at a given time, and an additional 18,000 residents of homes for senior citizens. There can be no doubt that there are similarly a large number of persons in the general community for whom issues such as competency to consent to treatment and competency to manage an estate are pertinent.

The legal framework applicable to these persons is contained in the *Mental Incompetency Act*.⁵¹⁶ Much of this *Act* remains unchanged since its original enactment as the *Lunacy Act*.⁵¹⁷ That *Act* gave the court jurisdiction to appoint a committee of the estate of a person found to be a "lunatic". The *Act* was broadened in 1911 to include not merely lunacy, defined as "idiocy and unsoundness of mind", but also "mental infirmity, arising from disease, age or other cause, or by reason of habitual drunkenness or the use of drugs".⁵¹⁸ The terms "lunacy" and "lunatic" were replaced by the terms "mental incompetency" and "mentally incompetent person" in 1937, the present definitions of "mental incompetency" and "mentally incompetent person" date from that time.⁵¹⁹ The defining characteristics of mental infirmity have not been amended since their inception in 1911.

⁵¹⁶ *Mental Incompetency Act* R.S.O. 1980, c.264.

⁵¹⁷ *Lunacy Act* (Ontario), 9 Edward VII (1909), c.37.

⁵¹⁸ See *Lunacy Law Amendment Act* 1 George V (1911), c.20. This section remains in effect, and is included as section 39 of the *Mental Incompetency Act*, R.S.O. 1980, c.264.

⁵¹⁹ See *Lunacy Amendment Act*, 1937, S.O. 1937, c.39, s.3.

Apart from some jurisdictional changes specifying which court could entertain the application for a declaration of mental incompetency, the only other major change to the *Act* occurred in 1964, when the *Act* was broadened to provide the court explicit authority to appoint committees of the person for mentally incompetent persons.⁵²⁰ Prior to this time, reflecting the same attitudes as have already been noted concerning the *Mental Hospitals Act*, the *Act* concerned only the estates of persons alleged to be mentally incompetent. Jurisdiction over the person was part of the residual jurisdiction of the court, under its *parens patriae* power, and prior to 1964 was presumably not considered important enough to warrant statutory definition. Again reflecting the attitudes of the 1960s already noted, the expansion of the *Act* to include guardianship of the person did not attract one whit of debate in the legislature, for or against.

The provisions of the *Mental Incompetency Act* regarding guardianship of the person have been almost unused. The entire *Act* has been long criticized by the legal profession as being largely out of date and unduly cumbersome. The provincial government itself was not unaware of the problems, and commencing in the early 1970s, representatives of the ministries of the Attorney General, Health, and Community and Social Services began meeting over the problem of guardianship legislation.

The reality was that in the absence of reliance on the *Act*, service providers operated largely in a legal vacuum. There is very little useful documentation on what consents were obtained for the treatment of those who were not competent to consent themselves. It is clear that treatment was provided on the consent of family members in many cases. As was the situation in mental health facilities, it would appear that competency determination was not approached as a discrete issue, warranting a determination of the patient's abilities prior to obtaining consent. Rather, it would appear to have been intermingled with family wishes, patient wishes, and treatment efficacy as a factor in a doctor's decision whether or not to treat.

A regulation passed in 1952 pursuant to the *Public Hospitals Act* was broadly believed to provide authorization for substitute decision making by a family member for medical decisions on behalf of a person who was unable to consent by reason of mental or physical disability.⁵²¹ No doubt it was relied on for this

⁵²⁰ *Mental Incompetency Act*, 1964, S.O. 1964, c.60, s.5.

⁵²¹ *Public Hospitals Act* O. Reg. 216/52, s.43, consolidated as R.R.O. 1980, Reg. 523, s.42. This section was

purpose. For decisions concerning medical treatment outside hospital, and for all personal guardianship decisions other than medical decisions, people operated largely without reliance on legal authority.

Issues in the broader community in the late 1970s and early 1980s tended to concern management of estates of persons found incompetent, rather than competency determination. Amendments to the *Powers of Attorney Act* in 1979 had allowed an attorney to specify that the grant of the power would continue, notwithstanding that the attorney became incompetent not so found.⁵²² This did not override the *Mental Health Act* provisions concerning the appointment of the Public Trustee as committee, however. When persons' estates were placed under control of the Public Trustee, their families rightly or wrongly felt entirely excluded from the management of the estates. The government eventually allowed powers of attorney to exclude the involvement of the Public Trustee even after the finding of incompetence under the *Mental Health Act*, subject to certain procedural safeguards.⁵²³

The then Attorney-General Roy McMurtry also appointed an advisory committee in 1984 to advise on "the law related to the management of the property of persons incapable of managing their own property". Chaired by Steve Fram of the Policy Division of the Attorney General's department, the committee was comprised of representatives of a wide range of government departments, lawyers, and financial experts. The committee issued an interim report in August, 1985, which provided a broad discussion of the existing law and of required reforms. It recognized that a determination of competency was an essential element of law reform, and formulated a recommended test of competency to manage property.⁵²⁴ The report was significant, insofar as it extended beyond psychiatric institutions and into the community.

amended in minor ways by O. Reg. 100/74, s.11, consolidated as R.R.O. 1980, Reg. 865, ss. 50, 51.

⁵²² These amendments are incorporated into the present *Powers of Attorney Act*, R.S.O. 1980, c.386, as section 5.

⁵²³ See *Mental Health Amendment Act* S.O. 1983, c.75, ss. 1, 3.

⁵²⁴ Ontario, Ministry of the Attorney General, *Interim Report on the Estates of Persons Incapable of Managing their Property*, (Toronto: Ministry of the Attorney General, 1985) (Chairman: S. Fram) at pages 55 ff.; *Powers of Attorney Amendment Act*, S.O. 1983, c.74.

The issues surrounding personal guardianship came to a head with the case of *Re Eve*.⁵²⁵ That case involved an application by a parent for committeehip of the person for her developmentally handicapped adult daughter, and authorization for the performance of non-therapeutic sterilization of the daughter. The case received wide publicity both when it was argued before the Supreme Court of Canada in June, 1985, and when judgment was eventually rendered in October, 1986.

The *Eve* case was significant for several reasons. It is best known as defining the scope of the *parens patriae* power of the court, in terms of what treatments of children and incompetent adults could be ordered by the court. More important for our purposes, it considered the meaning of a Prince Edward Island regulation identical in wording to the Ontario regulation under the *Public Hospitals Act*, which had generally been believed to provide authority to perform medical treatment on the consent of the next of kin of an incompetent adult. The court interpreted the regulation as follows:

As will be evident from a reading of s.16, [the enabling legislation] the purpose of the Regulations is to regulate the construction, management and operation of hospitals. They are not aimed at defining the rights of individuals as such. Section 48 of the regulations [i.e., the section at issue] (which appears to have been enacted under s.16(k)) does not so much authorize the performance of an operation as direct that none shall be performed in the absence of appropriate consents, except in cases of necessity. The enumerated consents and necessity are at law valid defenses in certain circumstances to a suit for battery that might be brought as a result of an unauthorized operation. So, for the purposes of managing the workings of the hospital, the regulations require that these consents be signed. They do not purport to regulate the validity of the consents; this is otherwise governed by law. Indeed, I rather doubt that the *Act* empowers the making of regulations affecting the rights of the individual, particularly a basic right involving an individual's physical integrity. For in the absence of clear words, statutes are, of course, not to be read as depriving the individual of so basic a right. In a word, the intent of the regulations is to provide for the governance of hospitals, not human rights.⁵²⁶

In essence, the court held that the regulation under the Prince Edward Island legislation operated in consort with the relevant legislation for findings of mental incompetency, and in no way superseded or provided an alternative to it. The parallel argument was applicable to Ontario, and it became far from clear that the regulation under the *Public Hospitals Act* provided authorization to treat incompetent patients on the consent of the next of kin.

⁵²⁵ *Re Eve* [1906] 2 S.C.R. 388, 13 C.P.C. (2d) 6, 31 D.L.R. (4th) 1, 8 C.H.R.R. D/3773, 71 N.R. 1, 61 Nfld. and P.E.I.R. 273, 185 A.P.R. 273, on appeal from the Court of Appeal for Prince Edward Island.

⁵²⁶ 13 C.P.C. (2d) 6 at 21 f.

Secondly, the court made it clear that the authority over an alleged mentally incompetent person depended on the exercise of process:

It follows from what I have said that the wardship cases constitute a solid guide to the exercise of the *parens patriae* power even in the case of adults. There is no need, then, to resort to statutes like the *Mental Health Act* to permit a Court to exercise the jurisdiction in respect of adults. But proof of incompetence must, of course, be made.

This marks a difference between wardship and *parens patriae* jurisdiction over adults. In the case of children, Chancery has a custodial jurisdiction as well, and thus has inherent jurisdiction to make them its wards; this is not so of adult mentally incompetent persons (see *Beali v. Smith* (1873), L.R. 9 Ch. App. 85 at 192). Since, however, the Chancellor had been vested by letters patent under the Sign Manual with power to exercise the Crown's *parens patriae* jurisdiction for the protection of persons so found by inquisition, this difference between the two procedures has no importance for present purposes.⁵²⁷

Furthermore, it was clear from the case that it was the Crown, and not the family, which had primary responsibility for the care of the person found incompetent. The powers of the family were delegated from the court. The common law, therefore, offered no assistance in providing for substitute decision making for an incompetent adult. In the Ontario context, absent court application, there was no one who had authority to consent to the treatment of an incompetent adult, and any such treatment could render the treating physician liable for battery. Given the unwieldy nature of the legislation and the court process as a whole, physicians, hospitals and other care providers were left in an untenable position.

This arguably remains the law in Ontario at the time of writing.⁵²⁸

In response to the mounting issues surrounding guardianship, the Government of Ontario had expanded the mandate of the Fram Committee to include all aspects of substitute decision making for mentally incapable persons. The tri-ministerial committee on guardianship was subsumed into this larger committee, and the membership of the committee was expanded to include professional representatives from social work, psychology, medicine and adult protective services workers.

⁵²⁷ 13 C.P.C. (2d) 6 at 23.

⁵²⁸ While the general validity of statutory substitute decision making powers may have been brought into doubt as a result of *Eve*, it is less than certain that *Eve* invalidates the provisions of the *Mental Health Act*. These provisions cannot easily be explained away as being merely an incident of hospital management and, in light of the specificity of the "best interests" factors set out in s.35(5), would arguably appear to codify the exercise of the *parens patriae* powers of the Crown.

The Fram Committee reported in December, 1987. They declined to recommend that their suggestions be extended to matters dealt with under the *Mental Health Act*, except that some of their recommendations concerning treatment are intended to dovetail with the *Mental Health Act* provisions.⁵²⁹ They do attempt to address the wide variety of issues regarding personal guardianship and committeeship of the estate outside the *Mental Health Act* provisions. They included draft legislation which was intended to replace the *Mental Incompetency Act* and the dubious regulations under the *Public Hospitals Act*. Their recommendations were intended to take account of persons with varying degrees of ability and in various personal situations. Its intent was to provide a "safety net" to assist persons of marginal abilities to maintain the maximum degree of autonomy consistent with their abilities. To this end, the Office of the Public Trustee would be expanded to include personal care decisions as well as estate matters, and would be given an administrative and supervisory role. The revised office would be called the Public Guardian and Trustee.

The Fram committee's essential premise was that persons ought to be presumed competent for all purposes, and that other persons ought to be able to rely on this presumption unless they have reasonable grounds to believe that the person is not competent to make the decision at issue. This position is essentially a codification of the common law. In the event that intervention is warranted, it should be the least intervention required under the circumstances.

While the Fram Report provides a wealth of useful suggestions concerning mechanics of guardianship and conservatorship, only matters relevant to the issue of competency will be discussed in detail here.

The proposed legislation defines capacity in the context of both personal care and financial decisions. Regarding the latter, the definition is contained in section 6 of the draft legislation:

⁵²⁹ How effective this would be is an interesting question. The lists of substitute decision makers under the proposed *Act* is different from that under the *Mental Health Act*, and there is no explicit discussion of which set of provisions is to take precedence. The commentary to the Fram report suggests that it is to apply only to voluntary patients in psychiatric facilities, not those persons who are civilly committed. More work may be necessary as to the interrelationships between these two systems prior to the enactment of the Fram draft legislation.

6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.⁵³⁰

The dual requirements of understanding and appreciation are similar to the definition of mental competence in the *Mental Health Act*.

Incapacity for personal care decisions is defined in section 41 of the proposed legislation:

41. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Once again, the relatively high standard of understanding and appreciation is required.

A substitute decision maker could be appointed for an incapable person in any of three ways. The individual could appoint the substitute by power of attorney signed at a time when he or she was competent. Such substitutes are referred to as "attorneys" by the report, and could be granted decision making powers over either estate matters or personal care matters or both. This is an extension of the existing law, which allows the appointment of an attorney only for estate-related matters. A power of attorney for personal care decisions would take effect only upon application by the attorney to the Public Guardian and Trustee. Due process safeguards would be provided, with the availability of a hearing before the District Court if required.

A substitute could further be appointed by court application. Such a substitute would be called a "guardian" if appointed for personal care decisions and a "conservator" if appointed for estate matters. The court would have the power to limit the authority of guardians to those areas where the individual lacks capacity, consistent with the definitions of capacity above. This again reflects a variation in existing law as expressed in the *Mental Incompetency Act*, where, apart from the distinction between estate-related matters and personal guardianship matters, an individual may be found only competent or incompetent; partial competency is not generally recognized in existing Ontario law.⁵³¹ Statements by

⁵³⁰ Fram report at page 186.

⁵³¹ See *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 (Dist. Ct.).

family members or other persons who have been acquainted with the person over a period of time could be included in the court application. If a summary disposition were desired, the application would also include reports of examinations by one physician plus another physician, psychiatrist, social worker or psychologist.

A conservator (but not a guardian) could also be appointed following a professional assessment of capacity. The individual would have a right to refuse such assessment, or to refuse the eventual appointment of the conservator following such assessment, in which case there would still be recourse to the other procedures of the *Act*. This assessment would be performed by a psychiatrist, physician, psychologist, or social worker. The determination of competency in the Fram Report is thus not necessarily rendered by a physician or psychiatrist.

There is limited discussion in the Fram Report as to when a determination of competence would be made. The report purports to be based on the premise that intervention is justified in the event that an individual is suffering serious harm, or where there is a risk of such harm. This principle is not reflected with particular clarity in the draft legislation, however. The appointment of conservators by professional assessment of capacity will occur "if a person's capacity to manage property is an issue".⁵³² The court process is triggered by an application to the court, and there is no restriction on when such application can be made.⁵³³ Applications to bring powers of attorney for personal care decisions into effect are similarly unrestricted in any way according to the time or situation of the grantor of the power.⁵³⁴

The report of the Fram Committee is the most recent official consideration of the issues before us. The fate of the Fram Report is not yet clear; the required legislation has not been introduced by the government, although an implementation committee has been appointed and chaired by Mr. Bernard Starkman. As the Enquiry considered the perspectives of the various interest groups and the options regarding standards of competence, the uncertainty with respect to the legal authority of the present substitute decision making provisions and with respect to those which will apply in the future has made these factors important and as of yet unresolved variables.

⁵³² Section 14(1) of draft legislation.

⁵³³ Sections 19 and 54 of the proposed legislation.

⁵³⁴ Section 45 of the draft legislation.

The present law does not define clear procedures and criteria to be used to assess competency in the various contexts within which it may be at issue. In a number of circumstances it is unclear who has the duty or the responsibility to either perform the assessment or to order it done and the test seems largely to have become an arbitrary one that is performed by the treating physician in a non-standardized fashion.

The absence of a clear threshold test and unambiguously defined burdens and procedures makes present determinations arbitrary and therefore possibly legally invalid. With respect to competency to make treatment decisions, it has been pointed out by those representing patients' rights that "since the term lacks clear guidelines, many psychiatrists have taken upon themselves the responsibility of determining whether or not the label applies to their patient at any particular time."⁵³⁵ These concerns indicate the need for implementation of a uniform and rational procedure to redress this problem.

C. Perspectives on Competency and Mental Health

The Enquiry must take into account a wide variety of perspectives, both in society as a whole and on our advisory panel. The submissions demonstrate this range of opinions and approaches. It should be recognized that the following generalizes the submissions and the views of the individuals on our advisory panel. No such summation can, of course, take account of the variety of viewpoints contained in each category.

At the outset, we note with some disappointment the lack of submissions from the client group itself. We have heard from a wide variety of social perspectives, but unfortunately relatively little from the group most affected by our determinations.⁵³⁶ While broad generalizations may be drawn from the submissions of other segments of society, it is unfortunately not possible to provide a reliable perspective on the views of the client group.

⁵³⁵ Angela Browne, "Submission to the Enquiry on Mental Competency", April 7, 1989 at 1. The submission continues with the suggestion that "this ambiguity may be partially responsible for many patients being labelled "incompetence" merely on the premise of refusing treatment alone."

⁵³⁶ The Enquiry has received briefs from the Council on Aging, the Manic-Depressive Association of Metropolitan Toronto, the Psychiatric Patient Advocate Office, Angela Browne and Don Weitz, a psychiatric patient activist. In addition, briefs were received from various local chapters of the Canadian Mental Health Association, which has a dual role of service provider and advocate for its residents. In addition, a number of our advisory panel were involved in the representation of patients and lobbying for patient rights in various capacities.

In addition, very few of the persons or groups making submissions identified themselves specifically as representing social or cultural minorities.³³⁷ We have been made aware by a number of organizations of cultural issues surrounding competency determination, in the context of race, gender, sexual orientation, and class. These issues will arise again in the discussion of the specifics of the briefs' recommendations, and in the development of our eventual set of standards.

The briefs dealt with competency to consent to treatment, to the near exclusion of other forms of competency. The comments on the briefs should be read with that in mind. It has been argued in some briefs, for example, that psychiatrists have a unique and central role in the determination of competence. Whether or not one agrees, the logic of the argument is relatively clear regarding competency to consent to treatment, an area where medical professionals have a particular expertise. It is less clear how the logic applies to a determination of financial competence for an individual on welfare, as it is not obvious that medical professionals have a particular expertise in the management of welfare cheques. The fact that many of the briefs were written with the competence in a treatment context in mind colours many of the arguments in the briefs.

In addition, consistent with the historical development of the issues surrounding competence but not consistent with the actual scope of problems surrounding competency determination, many of the briefs reflected experience based in the mental health system. While these perspectives have been useful and important, the briefs have provided less assistance regarding persons in other types of facilities and persons of marginal competence in the community, particularly as regards conditions other than mental illnesses and developmental handicaps.

Keeping those comments in mind, an overview of the perspectives presented in the briefs is as follows.

We received a number of briefs from families of persons with psychiatric problems, particularly schizophrenia. These briefs chronicled the difficulties that the families have had in dealing with the problems of their family members encountered within the existing legal framework. Frequently, a brief would recount how a son or daughter would refuse treatment, resulting in recurrence of the

³³⁷ Briefs were received from the Ontario Human Rights Commission, the Elderly Welfare Unit of Jewish Family and Child Service, and the Coalition for Lesbian and Gay Rights in Ontario. In addition, we were fortunate to have Terry Dotis, a Native Canadian social worker on our advisory panel.

illness. Some parents have explained their fear for their own physical safety, in the event that the child had a tendency to become violent in this situation. Most also feared for the son or daughter's safety, and we have heard painful accounts of eventual suicides of some of the family members involved. The families certainly find it painful to watch the son or daughter functioning at a level which they regard as below his or her potential, particularly when the illness is one for which there is an available treatment. Even when the treatment may not be entirely effective or may have some difficult adverse effects, as some so poignantly put it, to not treat is perceived as closing the door on hope.

The concerns of these deponents is that the current law precludes people in need from receiving the restraint and treatment they require. They perceive that even when they are aware that the son or daughter is on the edge of a recurrence, that legal standards preclude the committal of the individual, and even if committed, may allow the son or daughter to refuse treatment. There is a perception and a resulting frustration that the family, who may have a particularly well developed understanding of the person who is ill and their illness, is excluded from decisions about the individual. This is perceived as largely a function of the existing law, which is believed to provide no forum for the views of the people in closest touch with the person who is ill.

The attitudes expressed are in some sense reminiscent of *Barsy*. At best, the law is perceived as being a blunt instrument in these circumstances, resulting in a perception that the system has become overly legally oriented. These submissions reflect some of the optimism of the 1960s, that psychiatry is a panacea for mental disorder, or can at the very least provide the patient with a much improved life.

How much the committal issue is a problem of law is open to debate. The *Act* does allow committal in the event that serious bodily harm to the self or someone else, or serious and imminent physical impairment of the self, is likely; the difficulty may be in prediction of these outcomes. In addition, it is only fair to note that the committal form signed by the attending physician does allow for the inclusion of facts communicated to the physician by other persons.⁵³⁸

Regarding competency, many of these briefs suggest that the present procedures for determination of competency and consent to treatment operate to allow patients of marginal competency to refuse treatment which would be in the

⁵³⁸ See *Mental Health Act* R.R.O. 1980, Reg. 609, Form 1, as amended.

best interests of the patient. The briefs often did not distinguish between the determination of competency in a treatment context, and the issue of whether the competent patient ought to be permitted to refuse treatment, although there was sometimes an explicit concern raised that persons whose refusal of treatment might be a predictable result of their illness ought not to be found competent to consent. The entire system was generally perceived by these individuals as being an impediment to the provision of needed treatment.

In fairness to the families who made submissions to the Enquiry, and with regard to the importance of family input, it does not always follow that the transfer of decision making power to the family is appropriate. It must be recognized that because of honest limitations on abilities or very occasionally bad faith, the increased role of the family in decision making may not be in the best interests of the patient. Some professional groups raised this concern with the Enquiry.³³⁹

The concerns of the families can be juxtaposed with the comments of On Our Own, a Toronto self-help group of former psychiatric patients, to the Standing Committee on Social Development during the hearings into the 1987 amendments to the *Mental Health Act*:

Let us make clear what psychiatrists mean by "treatment." They do not mean simply having a pleasant little chat about your difficulties. They mean filling you full of mind-altering drugs, if necessary against your will. The most popular drugs among the psychiatric set are the neuroleptics. The Physicians' Desk Reference lists dozens of side-effects from these drugs, among them sudden death. Of course, no one here should have to be reminded of that side-effect after the inquest in 1980 into Aldo Alviani's sudden death at Queen Street Mental Health Centre at the age of 19. He died from the forcible administration of these same drugs. His death by "therapeutic misadventure," as the coroner so quaintly put it, was not unique. Many people, while under the tender ministrations of psychiatry, die while on adventures they did not willingly embark on.

...

Many who survive neuroleptic treatment suffer from irreversible brain damage, including tardive dyskinesia, another known side-effect of neuroleptics. This condition is characterized by uncontrollable convulsions of the face and limbs, sometimes accompanied by drooling and other unsightly manifestations that by making the patient look crazy, seriously impair her or his ability to find housing, employment or social acceptance.³⁴⁰

In the eyes of these people, treatment is not a panacea, or even a desirable option. It is rather a threat to the well-being of the individual. Following Thomas Szasz,

³³⁹ See brief of Sarnia-Lambton Health Unit.

³⁴⁰ Ontario, Standing Committee on Social Development, (28 May 1987, afternoon) at S-21 ff. Quotation marks in original.

these people are likely to argue that "treatment" of "mental illness" involves the application of a power dynamic of the socio-medical establishment, an application of medical categories to human behaviour in a context which is inappropriate. Needless to say, these opinions are controversial.

On Our Own also made some rather pointed remarks about competency determination:

Bill 190 [the 1987 amendments] defines competency as requiring that the patient understand the nature of her or his illness and the nature of the treatment proposed, as defined by the psychiatric profession. That means that if you know that you are not ill and that the so-called treatment to which you are subjected is dangerous, you are automatically deemed incompetent. In Brian McKinnon's accurate analysis, "Competence is just a pretty word for compliance."

A psychiatrist who does not like your face, your race, your politics, your sexual orientation or any aspect of your lifestyle can get you ruled incompetent if you disagree with anything he or she says.⁵⁴¹

Predictably, persons with these views favour strong due process safeguards, and are relatively unconcerned about possible delays to treatment that result therefrom. Their opinions are in direct conflict with those of the families discussed above, in their treatment of persons who deny their illness.

To be fair, these comments give short shrift to the 1986 amendments to the *Mental Health Act*, which gave an individual the right to a hearing to challenge the psychiatrist's opinion as to competence, and an appeal on matters both of fact and law to the District Court of Ontario. This right was never seriously challenged during the 1987 debates. While the group quoted above would see this review and appeal mechanism as problematic in that the opinion of the physician making the initial determination would be perceived as receiving too much weight, it is nonetheless too simplistic to imply that a patient is subject to the whim of an individual physician.

The two sets of opinions expressed thus far obviously represent extreme viewpoints. The former is a call to a more physician-centred, medical model of health law, in which it is implied that strong legal safeguards are unnecessary and in conflict with the best interests of the patients. The latter would favour even more strict regulation of psychiatric medicine. The advisory committee of the Enquiry is aware of both extremes, and the complications which they create for the development of an understanding of mental competency.

⁵⁴¹ Ibid at S-23.

The community of service providers in mental health facilities has indicated a number of concerns to the Enquiry. Their primary conundrum is that the existing law creates a situation where individuals may be detained in a psychiatric facility, but may refuse treatment. They are uncomfortable in this situation, and do not see a role for themselves. They feel they are cast in the role of gaoler, and they are very uncomfortable in that role. Some professional organizations also explained to the Enquiry that patients who refused to be treated could be violent, thus obstructing the therapeutic environment for other patients and creating a safety risk for other patients and staff.⁵⁴² The determination of competence in matters of treatment is perceived as part and parcel of those problems.

The correlation between competence and the refusal of treatment is somewhat problematic. In the event that an individual is found incompetent, a patient representative is still required to consent to the proposed treatment. In theory, all the determination does is determine who is to consent to or refuse the treatment.

The practical results are somewhat different. Firstly, the *Act* provides that no treatment may be given pending a review of competency. The review therefore delays treatment by the time needed to convene a review board and to receive the board's decision, normally one to two weeks. Treatment is also normally precluded pending an appeal of the review board's decision. The *Act* does allow a judge to order treatment pending appeal, but this requires a motion in the appeal, and some judges have refused these motions. In that event, treatment might be delayed by some months.

In addition, in the event that an involuntary patient is eventually found incompetent, the *Act* does allow for an application to the review board in certain circumstances, to treat the patient notwithstanding the refusal of consent of the patient representative. This option provides some redress for the concerns of the physicians that they have no role if there is confinement without treatment. This provision of the *Act* is currently being challenged under the *Charter*, however.

Also of concern to care-givers in psychiatric facilities is the quantity of time and other resources consumed by assessment and review procedures. There is mounting frustration that medical practitioners are spending so much time on these issues that their ability to spend time treating patients is compromised to the

⁵⁴² See for example, the brief of the Ontario Nurses Association.

detriment of all patients. Competency is of course only a part of a larger problem here. Most of the review board hearings attended by physicians involve challenges to committal.⁵⁴³

There is similarly a concern among practitioners outside of psychiatric facilities that they will become subject to the more formalized system of competency evaluation present in psychiatric facilities. Such a concern is presented, for example, in the brief from a chief of geriatric medicine in an eastern Ontario hospital:

There should be no intrusion of the ill-equipped officials of the Provincial Health Ministry into this matter, either by taking the decision making out of the hands of the experienced medical men who know the case best and have the interest of the patient at heart along with a sound knowledge of forensic medicine and medicolegal factors. A comparison of how certification of the insane was carried out before the enactment of this ill conceived *Mental Health Act*, and how it is being done since, shows that there is a serious danger of any changes in the procedure for deciding the competency of patients being premature and unwise.

With the present shortage of doctors in this Province, every effort to reduce the time they have to spend in administrative work, such as administering more complex regulations than exist now for deciding the mental competency of patients as opposed to diagnosing and treating the patients concerned, is to be deplored. There is no question that the burden of administration over the last few years has been needlessly increased at the same time as the work of doing first-line medical care has been increased also. With the acceptance that we have the knowledge and experience required to discharge our responsibility towards the public's ailing members, your enquiry should proceed to ensure that we can discharge those responsibilities with the fullest economy of effort and dispatch.⁵⁴⁴

The paradox of this position is that the medical professionals tend to feel very strongly, particularly in the context of competency to consent to treatment, that they should be the ones to determine competency; yet there is concern about the amount of time involved in making such determinations.

This brief is also interesting because it describes the system currently in use in the hospital as "flexible, quick and simple and having given rise to no problems or abuses, legal, medical, or moral." This summation clearly does not describe the procedure under the *Mental Incompetency Act*. Assuming, as would appear to be implied, that incompetent elderly persons are being treated in the facility, such treatment in law is an assault for which the treating physician might be held liable

⁵⁴³ In the period April 1987 through March 1988, there were 1174 review board applications related to civil committal and 133 related to any form of incompetence in the ten provincial psychiatric hospitals. In this period, there were 423 determinations of incompetence to consent to treatment in these facilities, resulting in 69 review board applications (16.3%).

⁵⁴⁴ Brief of C.M.C. Smelt, M.D., Chief of the Department of Geriatric Medicine, Hotel Dieu Hospital, Cornwall.

in civil law. Most lawyers would consider this to be a legal problem. Either the staff of the facility in question are unaware of this difficulty, or they are content to perform a technical violation of the law to ensure the treatment of the patient, an end which they honestly, and perhaps justifiably at least in some circumstances, believe to be a higher good. The treatment of the patient is identified with the health of the patient, and it is perhaps characteristic of submissions from medical professionals that law is considered from the perspective that patient health should not lightly be compromised.

There is further a sense among service providers, and particularly physicians, that a once coherent system of health care is losing focus. That concern is endemic in the provincial health care system at this time, and perhaps what we are seeing is in part a reflection of a broader anxiety. The comment quoted above which indicates that the government ought not become involved can certainly be perceived as part of that larger concern. The frustration may also in part be an unexpected result of the technological developments in psychiatric medicine, in that patient stays in hospital are now shorter. With the introduction of new drugs, many patients were in a position to leave the facilities. The recidivism rate is high, though, and psychiatrists have often been confronted with the frustration of the revolving door syndrome.

The frustration is also perceived as a reaction to the law permeating the practice of medicine, in the twenty-five years after *Barsy*. It is not simply that law has entered the psychiatric institutions; it is further the perception by some members of the medical establishment that they have been placed on the 'defensive' by the law, and there is a sense that this is fundamentally unfair, as the following comments by a psychiatrist indicate:

The civil right movement began in the late '50s and came into its own in the '60s. It is a sobering reminder to us of the social status of our patients that the civil rights movement focused on almost every other underprivileged group before they turned their attention to the psychiatric patient. This did not occur in any systematic fashion until the middle '70s. Up until that time, the only advocates that our patients had were us; the professional staff in the hospitals who were caring for them. I believe that most of us took that advocacy role quite seriously. Perhaps that contributed to the reasons why we were targeted by civil rights advocates. The professional staff is their greatest competition, and hence the greatest threat to their hegemony in this area.

As public awareness of human rights grew, the plight of the psychiatric patient seemed more and more blatantly out of step with the times. It was clearly in the interests of the pressure groups for reform to paint as black a picture as possible and to discredit the professional staff who were seen as part of the problem. So all of the skeletons were paraded out of the closet, and the debunkers had a field day. Thomas Szasz, R.D. Laing, Ivan Illich, I can name only a few.

We did not respond very effectively. We ignored the challenge or allowed ourselves to be trapped into positions that seemed to set us against patient's rights. Some of the more naive among us (myself included) believed that our opponents could be won over by sweet reason and a non-confrontational approach. We misjudged. They were out for blood. And in the present climate of anti-scientific and anti-establishment scepticism, we suddenly found we had no allies except perhaps the patients themselves. And not all of them were on our side either.⁵⁴⁵

Whether or not one agrees with the history expressed, the frustration is clear. The perception is not merely that the practice of medicine in this area has become the focus of law; it is also that the professional staff, whose *bona fides* are by and large beyond reproach, have been cast as the villains of the piece.

A description of a "typical" medical approach becomes more complex, however, as the medical establishment becomes increasingly aware of the ethical, and perhaps even therapeutic, value of individual integrity. The medical community itself is attempting to re-affirm to itself that medicine is more than simply the science of drug administration. The following passage written by an eminent psychiatrist attempts to address this issue in the context of legal rights for psychiatric patients:

Since our society places such a high value on freedom and autonomy, it is likely that the vast majority of our patients value this as well. To ignore the value they place on freedom by resorting to paternalistic behaviour is to de-humanize them and risk damage to their self-esteem. We no longer take away patient's belongings because we recognize that this can have a deep and long lasting effect on self-esteem; the same is true of civil and legal rights. Society has a right to protect itself. Individuals have a right to their day in court in order to maintain self-esteem at some level and thus fight the dependency, passivity and ignorance which is an inevitable by-product of paternalism. Clinical studies will have to address the meaning of autonomy and the definition of a lack of autonomy. In addition, patients who are recipients of paternalistic approaches to treatment will be compared to patients who have an opportunity to exert their civil rights to see if there are differences in self-esteem. Studies such as these could influence ethical belief systems and help society to find the correct balance of competing values.⁵⁴⁶

The members of the legal establishment who have taken the most active part in the debate regarding mental health law in general and competency in particular have, by and large, approached the issue with a fundamental concern for the civil liberties of the patient. The enactment of the *Charter* has further directed legal thinking in this direction.

⁵⁴⁵ J.C. Deadman "Perspectives on Mental Health Legislation". Presentation to Psychiatric Rounds, Scarborough Grace Hospital, 3 April 1987.

⁵⁴⁶ B.F. Hoffman "Contemporary Ethical Issues Surrounding Electroconvulsive Therapy". (1986) 11 *Psychiatric Journal of the University of Ottawa* 90.

The role of a lawyer is to act on the instructions of his or her client. As a result, lawyers are concerned about finding a legal forum to press for the interests of the client. There is, therefore, a perceived need among lawyers representing patients for review board hearings and due process safeguards. Without a forum to act for the patient, the lawyer is likely to experience a confusion similar to the doctor who cannot treat a confined patient. There is no understanding of what role they are to play, or how they are to advocate the interests of their clients. The approach of the legal community is not likely to be that the rights of the patient are so sacrosanct that they may never be violated, although frequently a lawyer may believe the standard for intervention ought to be relatively high. It is rather that such rights ought not to be removed absent the client having a "day in court", or at least a review board hearing.

If the physicians stand accused by some of importing a medical set of criteria to the field of mental illness, the lawyers should stand equally accused of importing legal criteria. The practice of law in many ways relies on legal hair-splitting, and the mastery of masses of legal categorization and detail. Some of the medical establishment have watched in amazement at the morass of legal concepts applied to mental health law in the past number of years: right to counsel, competency (in a number of separate forms, each legally distinct from the others), right to informed consent, right to treatment, right to refuse treatment, right to view clinical records, right to challenge transfers within or between psychiatric institutions by way of habeas corpus, judicial review, appeals, review board hearings, rights advisors, patient advocates, duty counsel; the list continues. To lawyers, these are merely tools of the trade. To the medical practitioner, these concepts are likely to be foreign, illogical, counter-productive, and not reflecting the real world of the hospital.

Whereas the physician may see these legal concepts and practices as mis-applied or over-applied, the lawyer with a concern about civil liberties sees these as being fundamental rights, the cornerstone of a democratic society. Where the physician may view treatment without the consent of the patient as a justifiable means to the centrally important end of the health of the patient, the civil libertarian is likely to view it as a de-humanization by society and violation of personal integrity which offends the very premise upon which a democratic society is based.

Competency is likely to be of fundamental importance to the civil libertarian. The common law has held that there are three requirements for valid consent to medical treatment: it must be voluntary; it must be informed, and it must be competent.⁵⁴⁷ From here, it is a small step to the position that interference with an individual's rights is justified in the event that the individual is not competent to make a decision himself. This position reflects the common law position as to the invocation of the *parens patriae* power of the court, as we saw above in the *Eve* case. Competence, therefore, becomes a threshold issue regarding interference with the rights of the individual, and complete due process safeguards become an essential protection to the individual. Rather than perceive competency determination as a barrier to treatment of persons in need, the civil libertarian is likely to perceive it as a fundamental determination of the individual's right to participate in society.

The legal approach, in its turn, stands fairly accused of ignoring a number of important points. Firstly, it is arguable that by definition, the client of the lawyer is not content with the way the system is working. As a result, the lawyer may get a warped perspective on the system. Secondly, when more than half of the present office consolidation of the *Mental Health Act* is composed of forms, the concerns of the medical professionals regarding the administrative burdens become more credible. The *Act* itself has become so complex that it is frequently misunderstood even by lawyers and review boards. It is no wonder that the professional staff of psychiatric facilities has difficulty. The patient's first line of defense is that the medical professional is unlikely willingly or blythly to violate the law. If the law becomes incomprehensible to the professional staff, that line of defense is lost, to the detriment of the patient.

A number of themes considered in the submissions and by the advisory committee to the Enquiry cut across these classifications. We have been made aware of the cultural nature of health care decisions and attitudes in general, and of issues of competency determination in particular. Misunderstandings can occur when patient and doctor do not share the same language.⁵⁴⁸ A commonly cited example concerns the branches of Christianity which place severe restrictions on medical treatment which may be provided, but the issue is broader than that. We have heard argument, for example, that the community of Native Canadians does

⁵⁴⁷ See, for example, *Hopp v. Lepp*, [1980] 2 S.C.R. 192.

⁵⁴⁸ See concerns expressed in brief of French Language Health Services/Services de santé en français and the City of Toronto Department of Public Health.

not understand health and illness in the same way that other parts of society do, and we have heard examples of mis-understandings of Native Canadian healing rituals by medical staff leading to inappropriate responses such as the segregation of the patient. Similarly, there is an indication that poor people, including most of the people in provincial psychiatric hospitals, may make different financial decisions from the relatively well-off.⁵⁴⁹ We have further been advised that persons with various forms of physical or neurological disorders are sometimes found incompetent because of physical difficulties in communication, rather than because of substantively limited understanding.⁵⁵⁰ A failure to understand these differentiations may result in an individual inappropriately being found incompetent. It is agreed that the deliberations of the Enquiry must take account of cultural differences, but it is less clear how this goal is to be accomplished.

The persons submitting briefs and the members of the advisory committee were further influenced by their own experience in their own environments. Persons practising primarily in the field of mental health, for example, had particular concerns about competency in the psychiatric setting. Health care providers in general tended to have particular concerns about competency in the context of treatment. This is as it should be: the advisory panel was chosen for its variety of expertise. The result was a wide divergence of interests and concerns on the committee.

⁵⁴⁹ See P. Bartlett "Reform of the Office of the Public Trustee". (1986) 24 University of Western Ontario Law Review 79 at pp. 86 ff.

⁵⁵⁰ See briefs of the Ontario Advisory Council for Disabled Persons and of the Ontario College of Physicians and Surgeons. In its very useful discussion of neurological issues surrounding competence, the College also points out that some persons with neurological deficits may appear competent, but may not in fact be so.

III. HISTORICAL DEVELOPMENTS IN ENGLAND

English law forms the basis of Canadian law regarding mental competence. Until well into the twentieth century, Ontario courts did not clearly distinguish between English and Ontario law. This situation has been modified somewhat in recent years by English statutory amendments, which have altered the conception of personal guardianship and limited rights to consent to treatment. Ontario law, where these amendments have not occurred, is still firmly rooted in the English law, and particularly the historical English law of the nineteenth century. A clear understanding of the development of English law in its social context is therefore necessary, to an understanding of current Ontario law.

The Origins: The English Experience Prior to 1800

It is convenient to commence the discussion of competency determination in England with the statute of *De Prerogativa Regis*, (1324) 17 Edw. II, stat. I. Chapter IX states:

The King shall have the Custody of the Lands of natural Fools, taking the Profits of them without Waste or Destruction, and shall find them their Necessaries, of whose Fee soever the Lands be holden. (2) And after the Death of such Idiots he shall render it to the right Heirs, so that such Idiots shall not aliene, nor their Heirs shall be disinherited.

Chapter X continues:

Also the King shall provide, when any (that beforetime hath had his Wit and Memory) happen to fail of his Wit, and there are many *per lucida intervalla*, that their Lands and Tenements shall be safely kept without Waste and Destruction, and that they and their Household shall live and be maintained competently with the Profits of the same, and the residue besides their Sustentation shall be kept to their use, to be delivered unto them when they come to right Mind; (2) so that such Lands and Tenements shall in no wise be aliened; (3) and the King shall take nothing to his own use. (4) And if the party die in such estate, then the residue shall be distributed for his Soul by the Advice of the Ordinary.

It is not entirely clear how much of the 1324 statute was a new departure, and how much of it was merely a codification of the existing feudal law. Certainly under feudal law, the lands of a person who was incompetent reverted to the feudal lord, and the ultimate feudal lord was the King.⁵⁵¹ Coke states that these

⁵⁵¹ See W. Blackstone *Commentaries on the Law of England*, (4th ed.), Vol I, (Dublin: 1771) at 303. As an example, see the series of cases regarding the lands of *Richard de Arden* (an idiot) reported at London, Public Record Office, Chancery Patent Rolls, Edward I, Vol. I (1272-1281) 282, 328, 361. The first two of these cases, dated respectively 1278 and 1279, involve the grant of Richard's lands to third parties by the King during Richard's lifetime, a grant which would be not be permitted under the 1324 statute. Our thanks to Mr. Kyle Rae, a doctoral candidate at the University of Birmingham, for drawing these cases to our attention.

two sections of the 1324 statute are entirely consistent with the common law of the period.⁵⁵² Other cases drew a distinction between the 1324 provisions and the feudal law, arguing that the old common law provisions fell with the system of land tenures leaving the 1324 provisions still in effect.⁵⁵³ Either way, it was the provisions of the 1324 statute which were in effect in early modern England.

The 1324 statute may well have been enacted largely to ease the financial burden on the Crown. A number of sections of the statute involve solidifying tax entitlements, such as from manor lords for the granting of knighthoods and from Normans. Land reversion to the Crown was established if the holder committed a felony. The provisions relating to natural fools⁵⁵⁴ can be viewed in this light; indeed, it is in this context that the provisions of the 1324 statute are discussed by Blackstone. During the life of the so-called fool, the King received the income from the fool's estate. Although the King was also required to provide for the fool, and although the fee in the land reverted to the heirs of the fool upon his death, this was no doubt a profitable enterprise for the Crown.

The same did not apply for the estates of lunatics under chapter ten. Under the terms of that section, the King was essentially similar to a trustee, holding the property for the benefit of the lunatic and his or her household. For this reason, the distinction between "idiocy" and "lunacy" was significant.

The powers of the King in matters of idiocy and lunacy were delegated to the Lord Chancellor, and thence by special commission under the Sign Manual. Historically, the power was delegated to judges of the Court of Chancery. Since well before the time of Blackstone, the inquisition into whether a person was a lunatic or a fool was under the writs of *de lunatico inquirendo* or *de idiota inquirendo*, as the case might be. The procedures associated with these writs involved a full jury trial. As a result, there are limited written reasons for findings of idiocy or lunacy, and we must rely on the secondary literature and *obiter* comments in the case law for guidance as to the understanding of these terms.

⁵⁵² *Beverly's Case of Non Compos Mentis*, 4 Co. Rep. 123a at 125b, 127a. Blackstone also takes this approach: see *Commentaries on the Laws of England*, Vol. I, (4th ed.), (Dublin: 1771) at 303.

⁵⁵³ See, for example, *Shaftsbury (Earl of) v. Shaftsbury* (1725), Gilb. Rep. 172.

⁵⁵⁴ After some debate, we have elected to use the terms in historical currency at the periods under discussion. While we appreciate they have become judgmental in their nature and offensive to modern sensibilities, we believe it is more desirable in a largely historical work to use the terms which reflect the attitudes of the period. They are an indicator, and a reminder when assessing the law, how the subjects of the legislation and case law were viewed by the legislators and the judges.

Consistent with the 1324 statute, the essential difference between natural fools and lunatics concerned the permanence of their condition. It was accepted that to be a natural fool was a condition of birth, which would continue unto death. It was further an extreme condition; Blackstone comments that "A man is not an idiot if he hath any glimmering of reason, so that he can tell his parents, his age, or the like common matters."⁵⁵⁵ Persons who were born deaf, blind, and unable to speak, however, were considered in the same class as natural fools.⁵⁵⁶ By comparison, the law always allowed the possibility, however remote, that a lunatic might be subject to a "lucid interval" or indeed might permanently recover.⁵⁵⁷

Coke, writing in the seventeenth century, provides the following taxonomy:

And it must be known, that there are four manners of *non compos mentis* — 1. Idiot or fool natural. 2. He who was of good and sound memory, and by the visitation of God has lost it. 3. *Lunaticus, qui gaudet lucidis intervallis*, and sometimes is of good and sound memory, and sometimes *non compos mentis*. 4. By his own act, as a drunkard; and it has been said, that there is great difference between an idiot *a nativitate*, and he who was of sound memory, and becomes, by the visitation of God, of unsound memory; for an idiot is known by his perpetual infirmity of nature, *a nativitate*, for he never had any sense or understanding to contract with any man; but he who was of good memory and understanding, and able to make a contract, and afterwards becomes by infirmity or casualty of unsound memory, is not so well known to the world as an idiot natural.⁵⁵⁸

By the eighteenth century, drunkenness does not appear to have been perceived as a foundation of lunacy.⁵⁵⁹

These categories were not mere curiosities. As we have seen, natural fools were treated differently from lunatics. Furthermore, prior to the nineteenth century, unless a person was found to be a lunatic, it was generally held that the statute had no application. As one 1745 case put it,

God forbid that a Weakness of Mind only should be a sufficient Reason for granting any Custody of such Persons and their Estates, for then violent people, Drunkards, careless, and silly, would be all taken

⁵⁵⁵ W. Blackstone *Commentaries*, at page 304.

⁵⁵⁶ *Ibid.*

⁵⁵⁷ See, for example, *Mr. Justice Dromer's Case* (1724), 2 Will Rep. 262.

⁵⁵⁸ *Beverley's Case of Non Compos Mentis* (1603), 4 Co. Rep. 123a at 124b.

⁵⁵⁹ It is not mentioned in Blackstone in this context. Indeed, in *Ex Parte Barnsley* (1745), 3 Aik. 184, it is rather perceived as specifically excluded from the definition of lunacy. Habitual drunkenness was also found not to constitute insanity in two early nineteenth century cases: *Ayrey v. Hill* (1824), 2 Add. 206; and *Wheeler and Batsford v. Alderson* (1831), 3 Hagg. Ecc. 574.

in; and the material Part of the Traverse [i.e., this appeal to the Court of Chancery] is, not to the Incapacity of Judgment, but to the more material Words of *unsound Mind* or *Insane Memoriae*, which all Persons must understand to be a *Depravity of Reason* or *want of it*. ... If a Man who is so weak as to be imposed on in the Execution of a Deed by the Artifice of another, or has spent his Money foolishly or weakly, such Men do not come within the Meaning of the Law in Cases of this Sort.⁵⁴⁰

The early modern jury was to determine lunacy within this framework.

Issues of incompetence arose, as they continue to arise to this day, in a variety of situations outside the proceedings for the appointment of a committee. Issues arose as to the competency of an individual at the time of marriage, of the signing of a contract, and, most frequently, of the signing of a will.

It was established in the middle ages that an individual could not plead his or her own incompetence to avoid the consequences of a contract.⁵⁴¹ This rule did not extend to heirs of the alleged incompetent person, however. By the early modern period, evidence of incapacity was further admissible on a plea of *non est factum*.⁵⁴² The rule against pleading one's own incapacity at the time of an act also did not apply in actions for annulment of a marriage, which were heard in the civil Ecclesiastical Courts, rather than the Royal Courts.⁵⁴³

On the limited information readily available, it is unwise to draw rigid conclusions. Nonetheless, a few comments may be made about legal attitudes to competence in the period before the nineteenth century.

Firstly, the attitude of the courts in applying the 1324 statute was that they were implementing Royal powers. While this power is occasionally justified with reference to the fact that the fool or lunatic is unable to protect himself, this is not generally coupled with an expression of sympathy for the individual involved. It is not that the courts were unsympathetic, or disregarded the interests of the lunatic.

⁵⁴⁰ *Ex Parte Barnsley* (1745), 3 Atk. 184 (emphasis in original). See also *Ex Parte Barnsley* (1745), 3 Atk. 168, a prior consideration of the same point on the same facts. The situation did not change until *Ridgeway v. Darwin* (1802) 8 Ves. 65, see further *infra*.

⁵⁴¹ *Anonymous* (1331), YB 5 Edw 3, fo. 70; *Anonymous* (1361), 35 Lib. Ass. pl. 10; *Stroud v. Marshall* (1595), Cro. Eliz. 398.

⁵⁴² *Yates v. Bowen* (1738), Strange 1104, Bull. N.P. 172. *Non est factum* is a plea of defense to a contract, where it is alleged that the defendant entirely misunderstood the nature of the document signed. It would appear that evidence of drunkenness was also admissible in a plea of *non est factum* throughout the early modern period, even though it ceased to be evidence of lunacy: *v. Pitt v. Smith*, 3 Camp. 34.

⁵⁴³ *Turner v. Meyers*, 1 Hagg. 414.

Indeed, the leading cases on the appointment of committees in the eighteenth century tend to preclude heirs from being committees, precisely because their interests would be opposed to that of the lunatic: to put it crassly, it was perceived that the heir had an economic interest in the lunatic's early demise, and therefore that the heir was an inappropriate committee.⁵⁶⁴ Rather, it was more that the case was approached as a dispassionate exercise in fact-finding.

Secondly, there does not appear to have been a developed sense of varying degrees of competence in this period. Certainly it would be understood that a natural fool would be incompetent for life, whilst a lunatic might have transient intervals of competence. Further, when competence was before the court in the specific context of a will or contract, other transactions of the individual would presumably not be directly affected by the finding of the court. Apart perhaps from a distinction between personal guardianship and committeehip of the estate, however, it would appear that once an individual was found incompetent by inquisition, he or she was incompetent for all purposes.⁵⁶⁵

Thirdly, some comment as to the standard applied by juries is appropriate. The questions to be faced by our Enquiry were as baffling two hundred years ago, as illustrated by the following comment of Lord Chancellor Thurlow in 1792:

There is an infinite, nay almost an insurmountable difficulty, in laying down abstract propositions upon a subject which depends upon such a variety of circumstances as the present must necessarily do. General rules are easily framed; but the application of them creates considerable difficulty in all cases in which the rule is not sufficiently comprehensive to meet each individual circumstance, which may enter into, and materially affect the particular case. There can be no difficulty in saying, that if a mind be possessed of itself, and that at the period of time such mind acted, that it ought to act efficiently. But this rule goes very little way towards that point which is necessary to the present subject: for though it be true, that a mind, in such possession of itself, ought, when acting, to act efficiently, yet it is extremely difficult to lay down, with tolerable precision, the rules by which such state of mind can be tried.⁵⁶⁶

⁵⁶⁴ v. 2 Eq. Ca. Abr. 581 ff.

⁵⁶⁵ This remains the situation in Ontario, under the terms of the *Menial Incompetency Act*, R.S.O. 1980, c.264, where apart from the distinction between guardianship of the person and of the estate, no partial guardianship is possible: v. *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 (Dist. Ct.). Cf. *Alberta Dependant Adults Act*, C.S.A. c. D-32.

⁵⁶⁶ *Attorney General v. Parnter et al* (1792), 3 Bro. C.C. 441 at 443.

Coglan v. Coglan may provide some insight as to the evidence called in cases of lunacy. That case involved a question of whether a person had a lucid interval, that is, a recovery of sanity, at least temporarily. The witnesses were "persons in the habit of watching the patient". At issue was whether the person's mind, "having thrown off the disease, had recovered its general habit".⁵⁶⁷

The standard for the validity of a will is expressed in *The Marquess of Winchester's Case*:

... it appeared by divers witnesses, and by many notorious circumstances, that the said marquess being sick, *et multa provevus senectute*, was not of sane and perfect memory, such as the law requires at the time of the making of the said supposed will (for by law it is not sufficient that the testator be of memory when he makes his will, to answer familiar and usual questions, but he ought to have a disposing memory, so that he is able to make a disposition of his lands with understanding and reason; and that is such a memory which the law calls sane and perfect memory).⁵⁶⁸

Note that the will at issue was that of a person of social position, so that the court's concern presumably reflects some concern at maintaining an established social order.

While there is evidence of a growing association in society between lunacy and disease, the medical model is entirely absent from the judicial determination. Medical professionals are not necessarily called as witnesses, and when they are, do not necessarily testify as to a medical diagnosis. They testify, rather, as to the behaviour of the person in question.⁵⁶⁹ The rise in influence of the medical professional and the medical model were to be a later phenomenon.

The Nineteenth Century

The nineteenth century generated most of the precedent cases which form the basis of modern law regarding determination of mental competency. While previous law continues to have its practical relevance today,⁵⁷⁰ it was the nineteenth century which developed what has become the standard test of mental competence in common law jurisdictions including Ontario.

⁵⁶⁷ Cited in *Attorney General v. Parnier*, *supra* at page 444.

⁵⁶⁸ *The Marquess of Winchester's Case* (1598), 6 Co. Rep. 23a.

⁵⁶⁹ See, for example, *Carrwright v. Carrwright* (1793), 1 Phil. Ecc. 90; *affid.* 1 Phil. Ecc. 122.

⁵⁷⁰ The need to have a "sound and disposing memory", for example, is reflected in recent Ontario cases which are concerned with the degree of memory possessed by the allegedly incompetent person: see, for example, *Re Schwartz* (1970), 10 D.L.R. (3d) 15 (O.C.A.) and *Re Davis*, [1963] 2 O.R. 666 (C.A.).

The nineteenth century was characterized by rapid developments in conceptions of mental illness, coupled with a new social awareness and unprecedented social legislation. The law moved into the realm of lunacy, developing substantive and procedural protections for persons who were or were alleged to be lunatics. By 1890, admission to asylums and madhouses required judicial sanction, and these institutions were subject to a rigorous regulatory framework.

The social concern in a sense parallels the concerns of the late twentieth century, in that lunacy was seen as an appropriate concern of the law, and both procedural and substantive protections were introduced to ensure appropriate standards of committal and maintenance. Unlike the late twentieth century, the legal advances did not tend to involve the empowering of inmates through the grant of statutory rights which the individual, if motivated to do so, could enforce. Rather, they tended to involve the administrative arm of the state inspecting and regulating, to ensure that the substantive standards were upheld. Thus, while the standards themselves were frequently very similar to current Ontario standards, the enforcement mechanisms were different. Because of the strong similarities in certain aspects of nineteenth century English law and current Ontario law, and also because of the historic importance of the period as the foundation of the current law of competence in Ontario, a detailed examination of the period is required.

The concepts of what it was to be mad were undergoing change.⁵⁷¹ The eighteenth century, the age of reason, had juxtaposed madness and reason; to be mad was to be devoid of reason. This condition might be caused by any of a variety of factors. Physicians, surgeons and apothecaries applied regimes of bleedings, cuppings, purges, immersions, tonics and potions. Some, following Descartes, believed that the madness was the result of disorder in the animal spirits of the body. Others argued for an excess of black bile in the bloodstream. Some still believed that madness was the result of possession, either by demons or by the

⁵⁷¹ In the following discussion of the history of madness before 1900, we have relied on a wide variety of sources. The following were found to be particularly useful: A. Digby *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985); W.F. Bynum, R. Porter and M. Shepherd *The Anatomy of Madness: Essays in the History of Psychiatry* (3 Vols.) (London: Tavistock, 1985); M. Foucault *Madness and Civilization: A History of Insanity in the Age of Reason*, tr. R. Howard, (New York: Random House, 1965); W. Parry-Jones *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and Kegan Paul, 1972); R. Porter *A Social History of Madness: Stories of the Insane* (London: Weidenfeld and Nicolson, 1987).

Holy Spirit, and the connection between madness and moral judgment, while arguably on the decline, still had some currency. The theories were legion.⁵⁷²

In the common eighteenth-century view, the mad were brutes, animals. In this, the inhabitants of the eighteenth century were in part the inheritors of the earlier tradition of the great chain of being, a force which still strikes terror in the hearts of university Shakespeare students. The brute/animal conception of the mad is more than a poetic image, however. It reflects the actual view taken of the lunatic. In the late eighteenth century, lunatics were still confined as animals, restrained by chains, lying on beds of straw, in cells without glazing in the windows.⁵⁷³

It would be extreme to say that all this changed in the nineteenth century. Some fundamentalist Christians apparently gave some credence to the concept of madness as the result of possession either by the devil or by the holy spirit. Many of the eighteenth century treatments continued well into the next century. Nonetheless, attitudes shifted considerably at about the end of the eighteenth century.

To begin with, there was a shift from the Cartesian to the Lockean conception of madness, away from the rationalist fascination with reason, the soul and animal spirits serving as the conduit between mind and body, to the empiricist philosophy, where knowledge was based entirely on perception and self-contained logical truths. Locke, who was a physician as well as a philosopher, was one of the first to apply the empiricist philosophy to the conceptualization of madness, in the mid-eighteenth century:

For they [the mad] do not appear to me to have lost the faculty of reasoning, but having joined together some ideas very wrongly, they mistake them for truths, and they err as men do that argue right from wrong principles. For, by the violence of their imaginations, having taken their fancies for realities, they make right deductions from them.⁵⁷⁴

Early in the nineteenth century, the issue in the treatment of lunatics became the correction of the association of ideas.

⁵⁷² A survey of medical attitudes to and treatments of madness in this period is M. Foucault *Madness and Civilization* (New York: Random House, 1965).

⁵⁷³ C.N. French *The History of St. Luke's Hospital* (1951) at 35; cited in A. Digby *Madness, Morality and Medicine* (Cambridge: Cambridge University Press, 1985) at 9.

⁵⁷⁴ J. Locke, *An Essay Concerning Human Understanding*, (1690), rpt. Everyman, 1965. Vol. I, p. 127.

The Christian evangelical movement further changed attitudes towards persons who were mad. The evangelicals spoke of the brotherhood of man, and the fundamental equality of all people before God. Whereas in earlier times the Church had, through its doctrinal support for the great chain of being, supported the conception of the lunatic as an animal or brute, the evangelicals of the late eighteenth and nineteenth centuries re-enforced the fundamental humanity of the lunatic. The acknowledgment that the mad were in fact human had an immense effect on the attitudes toward the mad, and on their treatment. It also shaped the form of the periodic challenges to the developing systems of institutionalization, although the liberal doctrines involving civil rights and a scepticism of the social and medical forces which grouped around the treatment of madness over the course of the nineteenth century were also significant in shaping these challenges.

The concrete effects of the changes in attitudes provide further insight into the changes in attitudes themselves. Asylums were built, and were considered places of treatment. In 1796, the York Retreat, a private institution developed by the Quakers, commenced its programme of moral treatment and management. This programme was based on providing patients with minimal restraints and maximum liberty within the institution. They were encouraged to take up domestic roles in the institution as far as their abilities would allow, in programmes of occupational therapy. An attempt was made to make the patient's stay in the retreat pleasant. A "half-way house" was established in 1811, to assist patients in the re-introduction to regular society. Following Locke, the process was to correct the misconceived perceptions and associations of perceptions, in a controlled environment. The intent of the process was to provide the patient with moral discipline, so as to re-orient him or her to the real world. The programme of moral management was widely imitated in other larger facilities early in the nineteenth century, with mixed success.

Medical treatment was still performed, of course, and the developing medical science provided a variety of new chemical remedies. By mid-century, opiates such as salts of morphia and tincture of opium (laudanum) were in use as sedatives. The cuppings and bleedings which had been the preferred treatments at the beginning of the century gradually ceased. Assorted bromides were used as depressants commencing in the late 1850s through the remainder of the century. Chloral hydrate came into use as another depressant and sedative in 1869.

The century also witnessed the increasing organization and professionalization of medical practitioners, both generally and specifically those involved in the treatment of mental illness. In the earlier years of the century,

medical education had been largely reformed. The study of the classic Greek texts had given way to the clinical methods using teaching hospitals in the 1820s, and by mid-century, the five universities' medical programmes were producing hundreds of graduates per year. Surgery was recognized as a profession separate and apart from barbering in 1745, and in the later eighteenth century began to be a discipline for which university training was available, originally at the University of Edinburgh. Commencing in 1815, apothecaries had to be licensed, although there was no prohibition introduced against unqualified druggists or mountebanks dispensing remedies. The *Medical Act, 1858*, for the first time created a register of physicians, surgeons, and apothecaries, and restricted the practice of medicine to persons on that register. Once again, however, there was no restriction introduced for persons offering cures, unless they held themselves out as medical professionals. Commencing at that time, university training became necessary to practise as a physician or surgeon. The profession was not what it is now by any means: apothecaries could still prescribe medications at mid-century, for example, and there was still no concept of a restricted drug which would be available only by prescription. Nonetheless, the professions were becoming increasingly powerful, increasingly respected, and increasingly specialized.⁵⁷⁵

A growing number of medical professionals developed a specialty in madness, serving as consultants to private madhouses or public asylums. This trend was further entrenched by the increased administrative control to which asylums became subject. By the end of the eighteenth century, members of the Royal College of Physicians were in charge of the licensing of private madhouses in the London Middlesex Westminster region.⁵⁷⁶ Commencing in 1828, Justices were to visit all private madhouses in the company of a physician, surgeon, or apothecary.⁵⁷⁷ Periodic visits by physicians were required of all private madhouses, and resident physicians were required in private madhouses containing more than 100 patients commencing in 1832.⁵⁷⁸ The Association of Medical Officers of Hospitals for the Insane was formed in 1842, and by 1853 was publishing its own journal.

⁵⁷⁵ In this paragraph, we have relied heavily on R. Porter *Disease, Medicine and Society in England, 1550-1860* (London: Macmillan, 1987).

⁵⁷⁶ *An Act for regulating Madhouses*, 14 George III (1774) c.49, s.2.

⁵⁷⁷ *An Act to regulate the Care and Treatment of Insane Persons in England*, 9 George IV (1828) c.41, ss. 2, 11, 20.

⁵⁷⁸ *An Act for regulating for Three Years, and from thence until the End of the then next Session of Parliament, the Care and Treatment of Insane Persons in England*, 2/3 William IV (1832) c.107, s.33.

By 1842, a standardized diagnostic taxonomy had been developed by the Association of Medical Officers of Hospitals for the Insane. The categories were mania, monomania, melancholy, dementia, moral insanity, idiocy and imbecility, general paralysis, and epilepsy. This taxonomy reflects many modern diagnostic categories: manias and melancholy approximating manic-depressive illness, moral insanity being essentially personality disorder, idiocy and imbecility reflecting developmental handicap, and dementia and epilepsy maintaining their nineteenth century names to this day.⁵⁷⁹ At the York Retreat in the first half of the nineteenth century, mania and melancholia constituted roughly 79 per cent of the diagnoses on admission,⁵⁸⁰ and this statistic appears to be approximately similar to the rate in a statistics of private facilities.⁵⁸¹

At the same time as concepts of madness were under development, the understanding of the law's role in society was undergoing a similar revolution. C.K. Allen, in his book *Law and Orders*, provides some sense of this legal explosion:

After 1832 we [i.e., the British] entered upon a period of social and legal reform unprecedented in our history. It is the fashion nowadays to speak as if our own age were the first and true inventor of "social legislation". To the eyes of our generation, many of the reforms of the nineteenth century seem so elementary and obvious that they are hardly recognized as reforms at all – if, indeed, they are not sneered at as blundering experiments. But in their day they were bold and often revolutionary measures, and hardly any of them was achieved without patience and determination. Every aspect of social life, and a great many aspects of what the *laissez faire* philosophy regarded as private life, came under review. Public health, education, local government and municipal reform, poor law, labour law and especially child labour, criminal law, company law, judicature and procedure, matrimonial and family law, land law – all these were the subjects, not of a few isolated *Acts*, but in most instances of a whole course of legislation. There were also great consolidating and amending statutes in different branches of technical law, criminal, commercial, and the law of property real and personal. In addition, Parliament grappled with all the highly technical questions arising from the development of many scientific inventions and discoveries, such as railroads, electricity, gas, therapeutics and many others. At no time and in no country has there ever been such a huge and varied volume of constructive legislation.⁵⁸²

This enthusiasm for legislative reform extended to the area of lunacy law, commencing even before Allen's suggested beginning date of 1832, but intensifying after that time. Lunacy was largely unregulated by legislation other than the 1324

⁵⁷⁹ See Digby at page 135 f.

⁵⁸⁰ Digby at 136.

⁵⁸¹ See Parry-Jones at 323 ff.

⁵⁸² C.K. Allen *Law and Orders* (London: Stevens & Sons, 1947) at 23 f.

statute until 1774, when private madhouses were required to be licensed.⁵⁰³ This *Act* contains thirty-five sections, and is re-printed in less than five pages. In the nineteenth century, there were at least forty-one statutes regulating lunacy and idiocy. Major legislative initiatives and consolidations were passed in 1828,⁵⁰⁴ 1845,⁵⁰⁵ 1853,⁵⁰⁶ and 1890.⁵⁰⁷ The 1890 *Act* contains three hundred and forty-two sections, plus five schedules including twenty-two forms. It consumes one hundred and sixteen pages of the 1890 statute book. By 1890, the *Act* had grown to include sections involving due process safeguards against wrongful committal; restrictions on the use of restraint; regulations as to who had an absolute right to correspond with or visit patients; diet; restrictions on who could treat patients and who could be employed in facilities; inquisitions in lunacy and committeeships; the appointment and duties of the Visitors of Lunacy and the Commissioners in Lunacy, being the two primary administrative bodies concerned with the administration of the *Act*; the performance of divine service; the records to be kept – and they were legion; the licensing of private madhouses; the construction and administration of county asylums; and provision for the expenses of pauper lunatics. Regulations could be made by Cabinet, by the Visitors, or by the Commissioners, depending on the subject matter at issue.

The increased social awareness of madness, as reflected in the mushrooming statute law, both created and reflected the increasing treatment of the mad. Prior to the eighteenth century, there had been one large establishment for the insane: Bethlehem Hospital, universally referred to as Bedlam. It had been founded in 1247, and by the early fifteenth century was catering to the mad. Originally part of the Priory of St. Mary of Bethlehem, the facility was given by Henry VIII to the City of London as a facility for pauper lunatics following the dissolution of the monasteries. Until the founding of St. Luke's Hospital in 1751, Bedlam was the

⁵⁰³ *An Act for regulating Madhouses*, 14 George III (1774) c.49. A statute regarding vagabonds in 1744 had permitted lunatics to be detained, if dangerous: see *An Act to amend and make more effectual the Laws relating to Rogues, Vagabonds, and other idle and disorderly Persons, and to Houses of Correction*, 17 George II (1744) c.5, ss. 20, 21.

⁵⁰⁴ 9 Geo. IV (1828) cc. 40 and 41.

⁵⁰⁵ *An Act for the Regulation of the Care and Treatment of Lunatics*, 8/9 Victoria (1845) c.100. *An Act to amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England*, 8/9 Victoria (1845) c.126.

⁵⁰⁶ *An Act to amend an Act passed in the Ninth Year of Her Majesty, "for the Regulation of the Care and Treatment of Lunatics"*, 16/17 Victoria (1853) c.96. *The Lunatic Asylums Act, 1853*, 16/17 Victoria (1853) c.97.

⁵⁰⁷ *Lunacy Act, 1890*, 53 Victoria (1890) c.5.

only public lunatic asylum in England. Five other asylums opened in the last half of the eighteenth century, in Manchester, Newcastle, York, Liverpool and Leicester.

For those with funds, there was also a flourishing "trade in lunacy", as the private madhouse business was disparagingly known. The general fees for maintenance and care in these facilities ranged from roughly fourteen to sixty pounds sterling per annum, although for those who could afford it, there was no obvious limit to the comforts which could be provided or the fees charged to pay for them. In one instance, an individual paid over six hundred pounds for a two year stay.⁵⁸⁸ Those less fortunate were likely to fend for themselves as best they could. It would appear that a very large number ended up in the work-house, poor house or the town gaol.

The developing social conscience of the nineteenth century changed that. Prior to 1808, the construction of asylums had been by public subscription, an act of charity by the local population. An 1808 statute provided the local justices with the authority to levy a tax for the construction of county lunatic asylums,⁵⁸⁹ and order that the maintenance of pauper lunatics in those institutions be paid by the parish if necessary. In 1845, it became mandatory that each county construct such an asylum.⁵⁹⁰ As time passed, increasing pressure was placed on parishes to ensure that their pauper lunatics were placed in the county asylum, rather than the workhouse. Meanwhile, the trade in lunacy continued throughout the century, although by 1890, the number of licensed houses was not being permitted to increase.⁵⁹¹

As a result of all these factors, the number of persons confined swelled over the course of the century. In 1800, there had been roughly 5,000 persons confined in asylums in Britain; by 1900, the tally had risen to roughly 100,000.⁵⁹² In 1808, the number of people officially recognized as insane was approximately 2.26 per

⁵⁸⁸ Parry-Jones at 125. Parry-Jones' study remains the most complete and detailed history of the private madhouse system in England. His focus is on the eighteenth and nineteenth centuries.

⁵⁸⁹ *An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals in England*, 48 George III (1808) c.96.

⁵⁹⁰ *An Act to amend the Laws for the Provision and Regulation of Lunatic Asylums for Counties and Boroughs, and for the Maintenance and Care of Pauper Lunatics, in England*, 8/9 Victoria (1845) c.126, s.2.

⁵⁹¹ *Lunacy Act, 1890*, 53 Victoria (1890) c.5, s.207.

⁵⁹² Porter, *A Social History of Madness*, at 20.

10,000 population; by 1890, it was 29.26 per 10,000 population.⁵⁹³ More specialized facilities for idiots were built commencing in the last quarter of the nineteenth century, and into the early part of the twentieth century.

This historical perspective yields a number of conclusions as to how madness was viewed in the nineteenth century.

Firstly, the century displays the beginnings of the professionalization of mental health. The medical establishment was on the ascendancy in terms of its power and authority, gradually defining an accepted body of medical truth against which charlatans were to be measured. Specialists were becoming established in the field of lunacy, and as the century progressed, lunacy became increasingly the domain of the physician. This process of occupying the field continued into the twentieth century.

Secondly, the regulation of lunacy was increasingly perceived as the business of government. It was no longer a matter of private charity, nor simply of private contracts between the madhouse operator and the family of the lunatic.

Thirdly, a sense arose that madness was to be controlled. It was not so much that the previous century had not attempted its own version of control. We have seen the collection of chains and manacles used in that period. Where the previous century restrained the corporeal persons, however, the nineteenth century arguably attempted to control the madness itself. In a treatment context, this is reflected later in the century by the increasing use of sedatives and opiates, and early in the nineteenth century by the use of moral treatment and management. Where in the eighteenth century, it was the mad person who was set against the society, in the nineteenth century, it was the madness in the person which was to be rooted out, and the mad person was increasingly encouraged to recognize that aim. The argument is made most forcefully by Foucault:

In fact Tuke [in developing a system centred on moral management] created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience. Tuke now transferred the age-old terrors in which the insane had been trapped to the very heart of madness. The asylum no longer punished the madman's guilt, it is true, but it did more, it organized that guilt; it organized it for the madman as a consciousness of himself, and as a non-reciprocal relation to the keeper; it organized it for the man of reason as an awareness of the Other, a therapeutic intervention in the madman's existence. In other words, by this guilt the madman became an object of punishment always

⁵⁹³ B. Hoggett *Mental Health Law*, (2nd ed.), (London: Sweet and Maxwell, 1984) at 6. Hoggett's statistics differ slightly from Porter's.

vulnerable to himself and to the Other; and, from the acknowledgment of his status as object, from the awareness of his guilt, the madman was to return to his awareness of himself as a free and responsible subject, and consequently to reason.⁵⁹⁴

Foucault may be overstating his case. Digby makes a persuasive argument that at least at the York Retreat, the institution founded by Tuke and referred to in the passage from Foucault above, governance was not as coercive as Foucault would have us believe.⁵⁹⁵ It is an open question of course whether Digby's defense of moral management is as applicable to the other institutions which imitated the Retreat's programme of moral management. It is also not clear what judgment, if any, Foucault passes on this transition. Foucault's essential point is well-taken, however: the form of control exerted was very different in the nineteenth century than the eighteenth.

The burgeoning law in the area mirrors the treatment developments. While the physical restraints of the eighteenth century were restricted by law and eventually had to be justified by the filing of a form on the clinical record, there was no restriction on medical treatments which could be performed on the patient.

Fourthly, there was a fundamental shift at the beginning of this period away from the conception of the lunatic as beast or animal. The lunatic was accorded the status of being human. Far from conflicting with the concept of control discussed above, it is in fact consistent with it. It was only with the humanization of the lunatic that moral management makes sense, and it is only with the humanization of the lunatic that it is the illness, not the individual, who is seen as the subject of control.

This trend of humanization of the lunatic is reflected in the public debate surrounding lunacy and confinement. Before the nineteenth century, the primary concern of those challenging abuses of the powers of committal was mis-labelling. They were concerned that the persons committed might not actually be mad. This concern continues through the nineteenth century, but added to it is the concern about the standards of care and of life in asylums. There was increasingly an honest concern and sympathy over the situations in which the mad and the poor found themselves. Lunacy became a matter of social policy.

⁵⁹⁴ Foucault, *Madness and Civilization*, at 247.

⁵⁹⁵ Digby at chapter 3 and especially at chapter 4.

This humanitarian approach did have its limits. The asylum in nineteenth century England generally continued to be seen as a place of confinement, and as a new method of enforcing social control. Until 1930, public asylums accepted only committed patients. For the bulk of the century, pauper lunatics could be admitted only following an order of a justice, and in 1890, all admissions were subjected to judicial scrutiny.

Statutory and Procedural Development to 1890

As we have seen, there was a veritable explosion in the statute law regarding the construction, regulation, and licensing of asylums and madhouses in the nineteenth century. By comparison, the law concerning competency determination was developed more in the realm of case than statute law. Nonetheless, the ten statutes touching on competency determination and the property of lunatics, so found by inquisition, which were passed between 1825 and 1890 codified, consolidated, amended, and supplemented the common law developments.

The process for inquiring into whether an individual was or was not a lunatic gradually became codified. At the beginning of the century, such an inquiry would be made by three Commissioners, appointed by the Lord Chancellor. In 1833, one Commissioner was empowered to make this determination,⁵⁹⁶ and commencing in 1842, the Commissioners were no longer judges, but rather barristers with at least ten years' standing.⁵⁹⁷ From 1842 to 1862, the Commissioners heard all inquiries in lunacy. Commencing in 1862,⁵⁹⁸ those cases to be heard by a jury were heard in the common law courts, while the Commissioners continued to hear cases in which no jury was requested.

The Commissioners were also *ex officio* "Visitors in Lunacy", and thus along with physicians appointed for the purpose, were charged with the duty of visiting persons found lunatic by inquisition. They reported their findings as to the care and treatment of the lunatic, and also the "state of mind and bodily health" of the lunatic to the Lord Chancellor. While the role of the Visitor was largely to ensure

⁵⁹⁶ *An Act to diminish the Inconvenience and Expense of Commissions in the Nature of Writs De lunatico inquirendo; and to provide for the better Care and Treatment of Idiots, Lunatics, and Persons of unsound Mind, found by such Inquisition*, 3/4 William IV (1833) c.36, s.1.

⁵⁹⁷ *An Act to alter and amend the Practice and Course of Proceeding under Commissions in the Nature of Writs De lunatico inquirendo*, 5/6 Victoria (1842) c.84, s.1.

⁵⁹⁸ *The Lunacy Regulation Act, 1862*, 25/26 Victoria (1862), c.86, s.4.

minimum standards of care and treatment of the lunatic, these visits also provided a check to ensure that persons who had recovered were not left perpetually without remedy. Commencing in 1862, the Visitors were also to visit individuals who were alleged to be lunatics, and report their findings to the Lord Chancellor.⁵⁹⁹ The costs of the Visitors were paid through a tax on the estates of the incompetent persons.

The frequency of these visits was regulated by statute. In the 1833 statute, the visits were to be at least annual.⁶⁰⁰ In 1862, the frequency was increased to quarterly.⁶⁰¹ In 1882, it was reduced to semi-annually.⁶⁰²

The statutes regarding inquisitions in lunacy were consolidated and amended in a major legislative initiative in 1853.⁶⁰³ For the first time, juries were no longer mandatory for the trial of lunacy, although the alleged lunatic continued to have a right to a jury, so long as he or she was competent to express such a wish. The alleged lunatic also specifically received a right to notice of the proceedings.⁶⁰⁴

According to the terms of the 1853 statute, the inquiry relating to the state of mind of the alleged lunatic was limited "to the question whether or not the alleged lunatic is of unsound mind, and incapable of managing himself or his affairs, at the time of the inquiry", unless the Lord Chancellor ordered otherwise.⁶⁰⁵ In 1862, this rule was expanded so that no evidence was admissible of anything said or done by the alleged lunatic more than two years prior to the hearing.⁶⁰⁶ Specific provision was made for the testimony of the alleged lunatic at that time as well.⁶⁰⁷

⁵⁹⁹ *The Lunacy Regulation Act, 1862*, 25/26 Victoria (1862) c.86, s.21.

⁶⁰⁰ *An Act to diminish the Inconvenience and Expense of Commissions in the Nature of Writs De lunatico inquirendo; and to provide for the better Care and Treatment of Idiots, Lunatics, and Persons of unsound Mind, found by Inquisition*, 3/4 William IV (1833) c.36, s.2.

⁶⁰¹ *The Lunacy Regulation Act, 1862*, 25/26 Victoria (1862), c.86, s.20.

⁶⁰² *Lunacy Regulation Amendment Act, 1882*, 45/46 Victoria (1882) c.82, s.4.

⁶⁰³ *An Act for the Regulation of Proceedings under Commissions of Lunacy, and the Consolidation and Amendment of the Acts respecting Lunatics so found by Inquisition, and their Estates*, 16/17 Victoria (1852) c.70.

⁶⁰⁴ *Ibid*, sections 40 to 43.

⁶⁰⁵ *Ibid* at section 47.

⁶⁰⁶ *Lunacy Regulation Act, 1862*, 25/26 Victoria (1862), c.86.

⁶⁰⁷ *Ibid* s.6.

Persons with small estates were subject to an abbreviated process, commencing in 1862.⁶⁰⁸

An 1830 statute⁶⁰⁹ regarding the management of the estates of incompetent persons was largely a consolidation of a number of eighteenth century statutes, and provides a sense of the framework in which estates were managed over the remainder of the century. The statute refers almost exclusively to the lands and stock holdings of the individual, and the emphasis is on the maintenance of the *status quo*. Thus, there were protections in the statute against forfeiture of land holdings of incompetents, and the duties both of the incompetent to the Lord of the Manor and of the incompetent's tenants to the incompetent remained in effect. The statute can thus be understood as ensuring the continuation of the entrenched social structure of the society. A committee had the power to manage the incompetent's interests consistent with the *status quo*, including the management of affairs regarding tenants, but any fundamental change in the *status quo*, such as the encumbering of the incompetent's interest in land, had to be approved by the Court of Chancery.

This basic approach to the management of estates continued throughout the century. Although gradually committees were given increased power, fundamental changes in the estate still required court approval.

The interrelation between the law surrounding inquisitions in lunacy and the other lunacy laws is complicated. Until 1890, there was no specific provision for the admission of persons found to be lunatic by inquisition into private madhouses or asylums. The general requirements of certification by physicians and sometimes a judicial order applied equally to persons who had been found to be lunatics by inquisition. While the administrative officials in charge of inspecting madhouses had the general power to release people wrongfully committed under some circumstances as early as 1828,⁶¹⁰ this power never applied to persons found lunatic by inquisition.

⁶⁰⁸ *Lunacy Regulation Act, 1862, 25/26 Victoria (1862), c.86, s.12.*

⁶⁰⁹ *An Act for consolidating and amending the Law relating to Property belonging to Infants, Femes Covert, Idiots, Lunatics and Persons of Unsound Mind, 11 George IV/1 William IV (1830) c.65.*

⁶¹⁰ *An Act to Regulate the Cure and Treatment of Insane Persons in England, 9 George IV (1828) c.41, s.37.*

Furthermore, a series of legislative enactments were developed to identify persons who were confined under the madhouse statutes, but whose estates were such that they should also have been placed under committeehip. Administrative officials were to report confined individuals who were believed to have property. A simplified process for appointing a committee was first introduced in 1845.⁶¹¹ It allowed one of the inspecting administrative officials to file a report with the Lord Chancellor as to the condition of the lunatic; the Lord Chancellor would then appoint a committee. The committeehip would continue until six months after the individual left the madhouse.

This provision was superseded in 1853. Under the new provision, the Commissioners in Lunacy were to report to the Lord Chancellor where the property of a person confined "is not duly protected, or that the income thereof is not duly applied for his [i.e., the lunatic's] benefit".⁶¹² Prior to a report, therefore, it was not sufficient that the person confined merely was not competent; there also had to be an abuse. The effect of filing a report would be the appointment of an inquiry, under the usual procedures.⁶¹³

It was not entirely clear during the century how much the finding of lunacy by inquisition limited the rights of the lunatic. It is clear that the commission did not preclude the drawing of a will; indeed, most of the nineteenth century case law regarding competence concerns the validity of wills. At issue in these cases was whether the testator had executed the will during a "lucid interval".

The law regarding contracts was not so clear. The Scots case of *M'Adam v. Walker and Another* makes the following comments concerning contractual capacity, in the context of a marriage contract:

Now their Lordships knew what the law of England was upon this point, and he was not aware that, in this respect, the law of Scotland was different. A man might marry, as well as form any other contract, if he was sane at the time. The legislature, with a view to prevent the marrying of lunatics during their lucid intervals, had enacted, that a commission of lunacy would avoid such marriages. This was conclusive that other contracts might be formed during their lucid intervals; and that the law did not avoid marriages, unless contracted during the course of time that the lunacy had been found to

⁶¹¹ *An Act for the Regulation of the Care and Treatment of Lunatics*, 8/9 Victoria (1845), c.100, s.95.

⁶¹² *An Act for the Regulation of Proceedings under Commissions of Lunacy, and the Consolidation and Amendment of the Acts respecting Lunatics so found by Inquisition, and their Estates*, 16/17 Victoria (1853) c.70, s.54.

⁶¹³ Presumably, this amendment in 1853 reflects the concerns which continue to be relevant to this Enquiry, that is, the maximum protection of those in need, with neither unwarranted intrusion into the private affairs of the care givers nor unwarranted drain on the public's administrative or financial resources.

exist. The usual way was, to direct an issue to try whether the party was of sound mind at the time of the contract; and if he was, it was of no consequence in what state he might have been, either before or after.⁶¹⁴

This case would suggest that the law regarding contracts was the same as that regarding wills, except that marriages would be void *ab initio* if one party was a lunatic so found. This is consistent with the case of *Snook v. Watts*,⁶¹⁵ which involved a mortgage. After the mortgage was signed, a commission was issued which found the Watts to have been a lunatic prior to the signing of the mortgages. However, this fact, as found by the commission, did not automatically void the mortgage, and a trial was held as to the abilities of Watts as of the date the mortgages were signed.

This would appear to be the law during the century when the order of the commission occurred following the signing of the contract, but made a finding of lunacy which included the time at which the contract was signed. The 1904 case of *Re Walker*⁶¹⁶ involved a contract signed after the order of the commission. The contract would have placed the assets of Walker in a trust to her benefit for her life, with the remainder going to her natural family. Notwithstanding the similarity of this contract to a will, the court held that it was void because of the order of the commission. The reasoning of the court for establishing different rules for contracts and wills is not entirely convincing. However, the fact that contracts signed during a commission were not defended in the nineteenth century on the same basis as wills were, i.e., that they were signed in a lucid interval, may indicate that *Walker* reflects the general understanding of the law.

As had been the case in the eighteenth century, the nineteenth century law presumed that an individual was competent, and in general the onus in a legal case was on the party alleging incompetence.⁶¹⁷ There were several exceptions to this rule, however.

Firstly, a finding that an individual was insane served to reverse the onus. For example, the onus in the *Snook* case was on the party seeking to uphold the contract, as a commission had found that Watts was of unsound mind at a time

⁶¹⁴ *M'Adam v. Walker and Another* (1813), 1 Dow. 148 at 177 f.

⁶¹⁵ *Snook v. Watts* (1848), 11 Beav. 105.

⁶¹⁶ *Re Walker* [1905] 1 Ch. 160 (C.A.).

⁶¹⁷ See *Attorney-General v. Parnther* (1792), 29 E.R. 632; *Snook v. Watts* (1848), 11 Beav. 105 at 107.

commencing prior to the execution of the contract.⁶¹⁸ When an application was made to supersede a commission in lunacy, the onus was on the lunatic so found to demonstrate recovery.

Secondly, wills comprised a special case, and a case where the onus changed over the century. Cases early in the century tended to require that a person challenging a will on the basis of competency demonstrate that the testator was not competent.⁶¹⁹ This requirement was based on the general common law presumption of competence. Commencing in 1838, however, a line of cases developed where proof of the competency of the testator was seen as part of proving that the will was valid. As such, it fell to the party propounding the will.⁶²⁰ The latter line of authority eventually prevailed.

The Ontario law adopted much of the English law without amendment. Similar provisions regarding the management of estates were applied here, for example, whereby the status quo would generally be maintained.⁶²¹ The rules regarding the effect of a finding of incompetence upon the ability to make a contract or will, or to marry and regarding the onus of proof in matters of incompetence were similarly adopted here.

Substantive Case Law

The nineteenth century cases introduced a certain amount of flexibility into the previous categorization of lunacy. At the beginning of the century, it ceased to be necessary that lunacy or idiocy, in the strict sense prescribed in the eighteenth century, be found prior to the issuance of a commission, and it became recognized that persons could be incompetent by reason, for example, of age or physical infirmity. The reasoning of the court is indicative of the new and more humane attitudes of the period:

⁶¹⁸ *Snook* at 107.

⁶¹⁹ *Dew v. Clark* (1826), 3 Add. 79 at 86; *Evans v. Knight and Moore* (1822), 1 Add. 229 at 232; *Bannatyne and Bannatyne v. Bannatyne* (1852), 2 Rob. Ecc. 472 at 477 (in this last case, the onus reversed because of a finding of lunacy by a commission).

⁶²⁰ See *Barry v. Butlin* (1838), 2 Moore 480 at 482; *Harwood v. Baker* (1840), 3 Moore 282 at 297; *Waring v. Waring* (1848), 6 Moore 341 at 355; *Cleare and Forster v. Cleare* (1869), 1 P. & D. 655 at 657.

⁶²¹ This remains the policy, for example, of the Office of the Public Trustee in Ontario: see Bartlett, "Reform of the Office of the Public Trustee", 24 *University of Western Ontario Law Review* (1986) 79. For court-appointed guardians, significant changes in the nature of the estate ought normally to be approved by the court: see for example *Children's Law Reform Act*.

... on the other hand, feeling, as Lord Eldon appears strongly to have felt, that persons, who are above all others entitled to protection, ought not to go unprotected. Another ground is this: A man may have passed a great and illustrious life; and by the course of nature his faculties may decay; so that he may not be fit either to govern himself or his affairs. It is unseemly, that he should be put upon the footing of a lunatic; and that a commission should issue in the ordinary course; which may affect the families of such persons in other times. It is supposed, and that opinion has gone forth very generally, that this unhappy disease runs into the posterity; and thence arises a grievous dilemma, that either such a person must be deprived of protection altogether; or in future times that distress to his family should be the consequence. Why should not a man be entitled to protection in this second state of infancy, as well as the first? The whole prerogative is this; that it falls to the King to take care of those, who cannot take care of themselves.⁶²¹

The older prescriptions of the causes of infirmity similarly were no longer as important. Thus in *Bannatyne and Bannatyne v. Bannatyne*, a case involving idiocy, it was understood that idiocy was not necessarily a result of birth, but could occur during one's lifetime.⁶²³ The view of that case continued to be that idiocy was a permanent matter, in which lucid intervals could not occur, however.⁶²⁴

Particularly in the first seventy years of the century, the distinctions between idiocy and lunacy were not irrelevant. While it was no longer in law necessary, the courts took great pains to decide whether or not someone was a "lunatic", the defining characteristic of lunacy being the presence of delusions. This approach as we have seen reflects Locke's philosophy, and Locke is indeed quoted at some length in one judgment.⁶²⁵ Also following Locke, the courts of the period tended to explicitly find that rational thought was not relevant to determining whether an individual was competent.⁶²⁶

In this approach, the court is not necessarily following the medical conception of insanity, although these conceptions incorporated much of Locke's philosophy. In *Frere v. Peacocke*,⁶²⁷ for example, the issue was whether a patient afflicted with moral insanity was thereby incompetent to make a will. Moral insanity was a recognized diagnostic category at the time, understood as "a disorder

⁶²² *Ex parte Cramner* (1806), 12 Ves. Jun. 445 at 449. The court in this regard is following the decision in *Ridgway v. Darwin* (1802), 8 Ves. Jun. 65.

⁶²³ *Bannatyne and Bannatyne v. Bannatyne* (1852), 2 Rob. Ecc. 472, esp. at 482 ff.

⁶²⁴ *Ibid* at 491.

⁶²⁵ *Dew v. Clark and Clark* (1828), 3 Add. 79 at 92 f.

⁶²⁶ *Ibid* at 111 f. and 169 f.

⁶²⁷ *Frere v. Peacocke* 1 Rob. Ecc. 442.

which affects only the feelings and affections, or what are termed the moral powers of the mind, in contradistinction to the powers of the understanding or intellect. ... If a person of quiet sedate temper, little subject to strong emotions, becomes excitable, violent, impetuous, thoughtless, and extravagant, to such a degree as to surprise his friends and relative, a suspicion is often produced that this change may depend upon a disordered state of mind.⁶²⁸ Moral insanity did not involve delusions. It was therefore held not to compromise an individual's testamentary capacity. The case of *Waring v. Waring*⁶²⁹ involves the inverse problem. The testator had been afflicted with monomania, a delusional disorder which was believed by the medical experts not to affect her testamentary capacity. The court disagreed, holding the testator incompetent because of her delusional state.

Once delusion had been proven and incompetence found, the court was hesitant to find either a lucid interval or a return to health. Certainly, this would not occur if any delusions persisted.⁶³⁰ There was extreme scepticism as to whether an individual had recovered in any event. Perhaps because, consistent with Locke, the lunatic's reasoning capabilities could be intact, there was a strong concern that the lunatic might only be pretending not to have delusions, and might in fact not be cured.⁶³¹ In one case, a judge went so far as to state:

Dr. Willis, on Mental Derangement, clearly states, that men often mistake, for a lucid interval, the mere absence of the subject of delusion from the mind; he says, no madman can be said to have recovered his reason unless he freely and voluntarily confesses his delusion; to which I take leave to add, that the confession or admission must be, not only freely and voluntarily made, but made without any design at the time of pretending sanity and freedom from delusion, according to the known or suspected view of the inquirer, and acting a part accordingly.⁶³²

Throughout much of the first seventy years of the century, the "confession" of past delusion was viewed as significant evidence of a return to sanity. Occasionally, even these confessions were viewed as attempts by the crafty lunatic to delude the court.⁶³³

⁶²⁸ Ibid at 446 f.

⁶²⁹ *Waring v. Waring* (1848), 6 Moore 341.

⁶³⁰ *Re D.O. Dyce Sombre, a Lunatic* (1849), 1 Mac. & G. 116 at 132.

⁶³¹ See *Dew v. Clark and Clark* (1826), 3 Add. 79 at 111 f.; *Waring v. Waring* (1848), 6 Moore 341 at 354 f.; *In re Dyce Sombre* (1849), 1 Mac. & G. 132.

⁶³² *Waring v. Waring* (1848), 6 Moore 341 at 354 f.

⁶³³ See, for example, *Prinsep and The East India Co. v. Dyce Sombre and Others* (1856), 10 Moore 232 at 264 ff.

All of this case law on lunacy may be juxtaposed with the conception of idiocy prevalent in the period. Idiocy was based on a failure of reasoning skills. Thus, where evidence of capacity to manage ones affairs is not particularly relevant to rebut an allegation of lunacy, it is extremely relevant to rebut an allegation of idiocy or imbecility. Thus in *Bannatyne*, for example, evidence that the alleged imbecile conducted his own banking, bought and sold stock and was capable of appropriate social behaviour were persuasive that the allegation was not well-founded.⁶³⁴ There was similarly no concern expressed in this case that the alleged imbecile might be feigning his recovery; such would not be possible.

This format was the categorical structure employed by the courts during the first seventy years of the nineteenth century. With the cases of *Banks v. Goodfellow*⁶³⁵ and *Jenkins v. Morris*,⁶³⁶ in 1870 and 1880 respectively, this categorical structure was largely re-assessed and clarified. The distinctions between lunacy, idiocy, and other forms of infirmity were minimized.

Banks was a case involving testamentary capacity. The testator had delusions that he was pursued and molested by devils or evil spirits and by a man who had been dead for some years. Notwithstanding these delusions, the jury found that he had been competent to make his will. At issue in the case was whether the delusions, which were not relevant to the making of his will, nonetheless affected his testamentary capacity. The court considered the medical texts on point, and found no consensus. A number of tests of capacity were considered, both from English and American cases. In the end, the court found that when the delusions did not relate to the subject matter of the will, testamentary competency was not compromised.

The case is significant for a variety of reasons. It settled two conflicting lines of cases as to whether or not partial incompetence existed. A relatively early line had taken the view that partial incompetence was possible. *Dew v. Clark and Clark* for example, again following Locke, commented:

It has been said then repeatedly by the counsel for the residuary legatees that this "partial insanity" is something unknown to the law of England. ... But if by that position it be meant and intended that the law of England never deems a party both sane and insane at different times upon the same subject; and

⁶³⁴ *Bannatyne and Bannatyne v. Bannatyne* (1852), 2 Rob. Ecc. 472 at 491 ff.

⁶³⁵ *Banks v. Goodfellow* (1870), 5 Q.B.D. 549.

⁶³⁶ *Jenkins v. Morris* (1880), 14 Ch. Div. 674.

both sane and insane upon different subjects (the most usual sense, this last, of the phrase "partial insanity;" and the one in which I take it to have been used throughout by the counsel for the next of kin), there can scarcely be a position more destitute of legal foundation; or rather, there can scarcely be one more adverse to the stream and current of legal authority.⁶³⁷

*Waring v. Waring*⁶³⁸ reached a different result. That case involved monomania, a diagnostic category where only one part of the mind was said to be delusional. Notwithstanding the medical opinion which created the category, the court held that delusions could affect only the entire mind:

For we must keep always in view that which the inaccuracy of ordinary language inclines us to forget, that the mind is one and indivisible; that when we speak of its different powers, or faculties, as memory, imagination, consciousness, we speak metaphorically, likening the mind to the body, as if it had members or compartments, whereas, in all accuracy of speech, we mean to speak of the mind acting variously, that is remembering, fancying, reflecting, the same mind in all these operations being the agent.⁶³⁹

Banks settled this issue, in favour of the existence of partial insanity.

The effect of *Banks* was to limit the importance of the distinction between lunacy and idiocy. While French, English, Italian and American medical texts are referred to in the judgment, there was clearly no medical consensus on the issue before the court and the texts do not appear to be particularly useful to the court in reaching a result. Following the tradition of earlier English cases, the court did not rely on diagnostic categories, but rather addressed the competency issue in the context of the will at issue. Unlike earlier English lunacy authorities, *Banks* did rely on the abilities of the testator in financial matters and on his rationality, in the context of a determination of testamentary capacity. It even went so far as to rely on the law of idiocy in reaching its conclusions.⁶⁴⁰

Banks was something of a watershed. It was the most comprehensive and organized decision on lunacy since *Dew v. Clark and Clark*, almost half a century earlier. It surveyed the variety of decisions existing at that point. It considered the medical texts in the area. It considered the variety of tests which had been applied

⁶³⁷ *Dew v. Clark and Clark* (1826), 3 Add. 79 at 93 f. Locke is quoted as explicit authority for this position in the paragraph following that quoted.

⁶³⁸ (1848), 6 Moore 341.

⁶³⁹ *Ibid* at 349.

⁶⁴⁰ at 566. Indeed, the test of competence propounded by *Banks*, being the understanding of the nature and effects of the act, the extent of the property to be disposed of, and the claims to which one ought naturally to give effect, is essentially the test of competence phrased in the context of idiocy: see *Harwood v. Baker* (1840), 3 Moore 282 at 290 f.

both in England and America. While the actual scope of the decision is narrow, the content of the decision is much broader.

Banks dealt with a situation where the delusions were clearly irrelevant to the subject matter of the will. At several points, the decision clearly limits itself to this situation. It further specifically states that relevant delusions would serve to invalidate a will:

Here, then, we have the measure of the degree of mental power which should be insisted on. If the human instincts and affections, or the moral sense, become perverted by mental disease; if insane suspicion, or aversion, take the place of natural affection; if reason and judgment are lost, and the mind becomes a prey to insane delusions calculated to interfere with and disturb its functions and to lead to a testamentary disposition, due only to their baneful influence — in such a case it is obvious that the condition of the testamentary power fails, and that a will made under such circumstances ought not to stand.⁶⁴¹

The case of *Jenkins v. Morris*⁶⁴² arguably represents the situation where a delusion could well have affected the subject matter of a contract. Jenkins was the representative of Price, who had leased his farm on the delusion that it was polluted with sulphur. If the land had been so polluted, the rents from the lease would have been higher than fair value; as the land was not so polluted, the rents were lower than the fair value. Despite the delusion, the jury found that Price was competent to sign the lease. At issue was whether the trial judge ought to have told the jury specifically that delusions related to the farm would compromise contractual capacity.

The English Court of Appeal held that there had been no misdirection. The three judgments of the appellate court judges are not entirely consistent. Baggallay L.J. was certain that Price was subject to insane delusions about his farm, but that "that is not a sufficient reason, in my opinion, why he should be held to have been incompetent to execute the lease in question, if the jury were satisfied that the delusions to which he was subject had not so far affected the general faculties of his mind as to render him incompetent to deal with the property which was the subject of the lease."⁶⁴³ Bramwell L.J. takes a similar line:

⁶⁴¹ *Banks v. Goodfellow* (1870), 5 Q.B. 549 at 565.

⁶⁴² (1880), 14 Ch. D. 674. See also *Birkin v. Wigg* (1890) 6 L.T. 80 and *The Imperial Loan Co. Ltd. v. Stone* (1892), 1 Q.B. 599 for similar situations where similar results were reached.

⁶⁴³ at 685.

It seems to me that the direction which he [i.e., the trial judge] gave to them [the jury] was, as might be expected from him, quite right, because what he says is, "It is a practical question – whether he was so insane as to be incompetent to manage his own affairs in the sense of disposing of his property, and even of property believed by him to be full of sulphur."⁶⁴¹

The status of the delusion in these remarks is markedly diminished from what would have been the case earlier in the century. Delusion is no longer the hallmark and defining characteristic of incompetence; it is now at best a factor to be considered in the general assessment of competence. The central issue is no longer the existence of a delusion, but rather the abilities of the individual involved.

The comments of Jessel M.R. show an even greater departure from the previous law:

... for it must be recollected, that although a man may believe a farm to be impregnated with sulphur and not fit for himself to live in, he may still be a shrewd man of business, and may even believe that the other side may not know of the impregnation of the farm with the sulphur, and that in consequence he may get a higher price for it than if it was known that it was so impregnated. He may have been perfectly right in his conclusion upon that subject, and the jury may have thought that it was so. The Judge, in fact, says that he was a shrewd man of business.⁶⁴²

Where there is some room in the reasons of the other two judges for argument that a contract which was signed under a delusion would therefore be void, Jessel M.R. seems to take the position that one views the world through the deluded eyes of Price. Price realizes in this scenario that the lessee does not know of the sulphur pollution. Price believes he can make a financial windfall. The windfall will occur, of course, only if Price is not deluded. Price's understanding that he can make a windfall is evidence of his competence, however. Therefore, the fact of the delusion, far from being evidence of incompetence, is an integral part of the proof of competence.

Arguably, the *Banks* case is an attempt to bring the law more into conformity with the scientific knowledge of the period. Consistent with the medical view of the condition, persons afflicted with monomania were to be incompetent only in the portions of their ability affected by the monomania. This reflects the defining characteristics of monomania as a diagnostic category, and the case therefore brings the legal reality into conformity with the clinical reality.

⁶⁴¹ at 686.

⁶⁴² at 683.

When the *Banks* and *Jenkins* cases are viewed together, however, a different interpretation is suggested. The move suggested is one away from diagnostic categories, towards a more purely legal standard. The distinction between lunacy and idiocy, which corresponded to an existing clinical distinction, becomes less relevant as the test of lunacy becomes more based on ability, and therefore more similar to the test of idiocy. The result is a movement away from issues of reality perception in the test of competence.

If delusion was the primary issue in the nineteenth century, at least up until *Banks* and *Jenkins*, how was a delusion to be understood? How was the court to know when an individual was deluded? As has already been discussed, rationality was not the issue. The ability to carry on one's own business and social affairs was relevant to a determination of idiocy, but not to a determination of incompetence due to lunacy. As has also already been noted, "confession" of prior delusion was viewed as an indicator of recovery, although there was an issue as to whether such confessions were disingenuous.

Lord Langdale M.R. in *Snook v. Watts* explains the difficulty at issue:

There is no subject, I conceive, more difficult, to investigate and satisfactorily to adjudicate upon in Courts of Justice than the state of a man's mind, with reference to his sanity or insanity, for the purpose of determining whether he is legally bound by or answerable for his acts; and independent of the difficulty of forming a distinct idea of what ought to be understood by the expression "soundness of mind", it is, in many cases, most difficult to determine, what indications of alleged unsoundness ought to be relied upon, and to distinguish between an insane man's delusions, and the erroneous opinions or the mistaken notions of a man, who is admitted to be generally of sound mind.⁶⁴⁶

The technical definition of "delusion" was established early in the century: "It is only a belief of facts which no rational person would believe that is insane delusion."⁶⁴⁷ A somewhat later case explained:

We cannot, however, err in saying, that insane delusions are of two kinds; the belief in things impossible; the belief in things possible, but so improbable, under the surrounding circumstances, that no man of sound mind would give them credit; to which we may add, the carrying to an insane extent impressions not in their nature irrational.⁶⁴⁸

These definitions are largely circular or so sufficiently obvious as to be of little practical assistance. The law paid some note throughout the century to the

⁶⁴⁶ *Snook v. Watts* (1848), 11 Beav. 105 at 108.

⁶⁴⁷ *Dew v. Clark and Clark* (1828), 3 Add. 79.

⁶⁴⁸ *Prinsep and The East India Co. v. Dyce Sombre and Others* (1856), 10 Moore 232 at 246.

proposition that eccentricity was not the same as lunacy, but that it could be difficult to delineate between these categories. A number of techniques were developed by the courts to identify when people were in fact delusional.

The alleged delusions of the individual were to be considered in the context of the individual's life prior to any alleged infirmity. This approach was taken, for example, in *Snook v. Watts*:

A man may be subject to some delusions, and one of the means, and perhaps the most accurate means, of judging whether these apparent indications ought to be relied upon as proving a general unsoundness of mind, is by a comparison of the alleged acts of insanity with other acts of the same person and the general course of his life; so that, on questions of insanity, a great deal more is to be taken into consideration than the particular acts of imputed insanity. When a man's ways and general course of life are such as to indicate sanity and a knowledge of his affairs, proof of one or more particular acts, though very strange in themselves, and though affording some grounds for imputing insanity, would not be a sufficient proof to show that all his acts were done under the delusion of insanity. On the other hand, when a man is thought by various persons to have been insane at a particular period, and to have so continued ever since, proof of one or more acts done afterwards apparently in the manner of a man of sound mind, would not, if unaccompanied by other proof and the application of some test or inquiry, prove, that the acts done were done under circumstances free from delusion, or, what is quite as much of importance, free from the influence to which persons acting under insane delusions are confessedly liable.⁶⁴⁹

Consistent with this approach, the wishes of an individual when known to be competent were considered in some cases. *Harwood v. Baker*, for example, was a case where a few hours prior to his death, Baker executed a will leaving his entire estate to his second wife, and disinheriting the remainder of his family:

Now if their Lordships had found from the other evidence that Mr. Baker had, while in a state of health, compared and weighed the claims of his relations, and had formed the deliberate purpose of rejecting them all in favour of his wife, but had omitted to carry that purpose into effect before the attack of illness under which he died, and that during that illness he had acted upon that previous intention, and executed a Will in question, -- less evidence of the capacity to weigh those claims during his illness might have been sufficient to show that the Will propounded really did contain the expression of the mind and will of the deceased. But when their Lordships find, that up to the date of his illness he had entertained a deliberate purpose of distributing a large portion of his property amongst his relations; and that he had never before the hour in which he gave the instructions for the disputed Will, expressed any intention to leave his property to his wife; and when their Lordships further find (as they cannot but believe to have been the case), that during his illness he had attempted to execute a draft of a Will, containing a disposition of a large portion of his property amongst his relatives -- to which, it is probable the deceased referred, when he remarked to Pollock that his Will had not been done satisfactorily before -- their Lordships are of the opinion that the Appellant has not made out by his evidence that the paper propounded by him as the Will of Mr. Baker really does contain his last Will and Testament.⁶⁵⁰

⁶⁴⁹ *Snook v. Watts* (1848), 11 Beav. 195 at 108 f.

⁶⁵⁰ *Harwood v. Baker* (1840), 3 Moore 282 at 313 f.

By far the most frequent test of whether or not an individual was suffering from delusions involved consideration of the appropriateness of their actions. It was not that the courts explicitly required that people behave in ways considered to be socially appropriate; indeed, the courts frequently reiterated that mere eccentricity was not to be confused with lunacy, although it was evidence for the court's consideration.⁶⁵¹ It was rather that there was an expectation that competent people would act in specific ways. The essence of this approach is explained in the following passage, which relates to testamentary capacity:

... where a mental aberration is proved to have shown itself in the alleged testator, the degree of evidence necessary to substantiate any testamentary act depends greatly on the character of the act itself. If it purports to give effect only to probable intentions, its validity may be established by comparatively slight evidence. But evidence, very different in kind and much weightier in degree, is requisite to the support of an act which purports to contain dispositions contrary to the testators probable intentions, or savouring, in any degree, of folly or frenzy.⁶⁵²

While it would be an error to place this approach on the level of a legal presumption such as would change the onus in a case, it is to be noted that the courts were fond of quoting the comment of Sir William Wynne that:

I think the strongest and best proof that can arise as to a lucid interval is that which arises from the act itself; that I look upon as the thing to be first examined, and if it can be proved and established that it is a rational act rationally done the whole case is proved.⁶⁵³

It is tempting to treat this line of thinking as result-oriented jurisprudence at its most blatant, which would be appropriate up to a point. It is certainly true that the courts acted much more favourably when the rights of a long-suffering family were in jeopardy at the hands of shady dealers. Where a result was upheld which at first glance might have appeared socially and morally inappropriate, the court often explained away the inconsistency. In *Barry v. Butlin*, where a will was upheld in disinheritance of the family, the court made a point of indicating that the testator was in a state of complete alienation from his son, and "in this state of complete alienation from his son, it is by no means unnatural to suppose that he would not make him the object of his bounty."⁶⁵⁴

⁶⁵¹ See, for example, *Dew v. Clark and Clark* (1828), 3 Add. 79 at 182.

⁶⁵² *Evans v. Knight and Moore* (1822), 1 Add. 229 at 237 f.

⁶⁵³ *Cartwright v. Cartwright* (1793), 1 Phill. 90 at 100.

⁶⁵⁴ *Barry v. Butlin* (1838), 2 Moore 480 at 489.

The test is more complex than that, however. We have seen that the nineteenth century adopted a programme of moral management. While largely based on Lockean philosophy whereby madness was the result of imperfect intuitions, the programme commenced in an environment constructed by the Quakers. The programme occurred in the context of a mock household in the asylum, complete with the moral framework of the Victorian family.⁶⁵⁵ Recall as well that 'moral insanity' was a classification known to the medical taxonomy as early as the late eighteenth century. This diagnosis might result for a patient who was irritable, abusive, deceitful, intemperate, dirty, idle, or engaging in inappropriate sexual behaviour, for example.⁶⁵⁶ In this way, it is not surprising that the test for insanity has a distinct moral component. It is not merely result-oriented jurisprudence; it also reflects the societal views of insanity current at the time.

With the passing of delusion as central to the understanding of lunacy, the following passage from *Banks* became the standard:

It is obvious, in either case, that to the due exercise of a power thus involving moral responsibility, the possession of the intellectual and moral faculties common to our nature should be insisted on as an indispensable condition. It is essential to the exercise of such a power that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect ...⁶⁵⁷

This test did not obliterate the relationship between moral choice and competence. Indeed, the ability to make choices not only consistent with reason, but also with morality, was explicitly required by the final clause of the passage quoted. Just as there was no explicit condition that the eccentric person obey moral codes, there was no requirement that the testator under *Banks* make moral dispositions of

⁶⁵⁵ See further Digby, *Madness, morality and medicine: A Study of the York Retreat, 1796-1914*, (Cambridge: Cambridge University Press, 1985) at chapters 3 and 4.

⁶⁵⁶ See Digby at 93 ff. This diagnosis was rare, at least at the York Retreat.

⁶⁵⁷ *Banks v. Goodfellow* (1870), 5 Q.B. 549 at 565. The passage continues:

and, with a view to the latter object, that no disorder of the mind shall poison his affections, pervert his sense of - right, or prevent the exercise of his natural faculties - that no insane delusion shall influence his will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.

While the entire quotation is sometimes cited, this latter passage must be read in light of the *Jenkins* decision.

property. The case is quite specific on that point. Nonetheless, the importance of the ability to reason in a moral fashion remains.⁶⁵⁸

The cases on competency determination in the nineteenth century reflect in a number of ways the social context of the period. The impact of the concepts of insanity which developed over the course of the period has already been discussed. The concept of persons who are competent being expected to make natural human choices is similarly fraught with cultural assumptions. The understanding that one's family is the natural object of one's bounty, absent radical estrangement, obviously reflects Victorian conceptions of family life. The cases are similarly replete with sexist, racist, and religious stereotyping. Persons of the Indian sub-continent were said to be given to "unrestrained sensual indulgence of every kind".⁶⁵⁹ Reservation was implied in another case about an individual alleged to be "a Methodist, or Calvinist, or evangelical, as it is called".⁶⁶⁰ A clear example of sexist assumptions involves a judge's view in 1885 of what the parties must understand in order to be competent to marry:

I may say this much in the outset, that it appears to me that the contract of marriage is a very simple one, which does not require a high degree of intelligence to comprehend. It is an engagement between a man and woman to live together, and love one another as husband and wife, to the exclusion of all others. This is expanded in the promises of the marriage ceremony by words having reference to the natural relations which spring from that engagement, such as protection on the part of the man, and submission on the part of the woman.⁶⁶¹

The cultural values of the period cannot be ignored when considering the resulting findings of incompetence.

We have seen that as the nineteenth century progressed, an increasingly organized and professionalised medical establishment gained increasing social influence in matters regarding lunacy. This shift is reflected to some degree in the litigation of the period. Certainly as the century progressed, medical evidence was

⁶⁵⁸ The parallels with modern arguments about competency determination are obvious. Like the nineteenth century court, this Enquiry has considered the relevance of the individual's wishes when competent, and the need to consider changes in personality. The central tension existing in the nineteenth century cases between the desire to reach a socially or rationally appropriate result, and the desirability of allowing individuals to live free of enforced moral choices, is as live today as it was a century ago.

⁶⁵⁹ *Princep and The East India Co. v. Dyce Sombre and Others* (1856), 10 Moore 232 at 242. This case may say as much about the attitude of the English court as it does about the alleged lunatic: Dyce Sombre was found to be insane in England, but quite sane in France.

⁶⁶⁰ *Dew v. Clark and Clark* (1828), 3 Add. 79 at 110 and 193 ff.

⁶⁶¹ *Durham v. Durham* (1885), 10 P. 80.

routinely included in the case. By 1849, the Court of Chancery had two physicians who routinely advised the court on matters of lunacy.⁶⁶² Nonetheless, the court guarded the actual determination of incompetence for the jury. The evidence of the medical witnesses was to be considered relevant but not determinative; juries were to form their own judgment, not relying on, but not disregarding the evidence of the medical witnesses.⁶⁶³

Some of the reluctance of the court may be the result of the evidence called. The following passage from *Evans v. Knight and Moore* refers to all evidence adduced in incompetency proceedings, medical evidence included:

Experience in this Court teaches us that evidence upon questions of capacity is almost always contradictory. The obvious grounds of conflicting evidence upon these questions are that evidence of capacity is, commonly, evidence of opinion merely; that of the witnesses, no two, possibly, have seen the party whose state is depose to at precisely the same time and under precisely the same circumstances; and that each again of the several witnesses, however numerous, measures, possibly, testamentary capacity by his own particular standard. These sources of discrepancy, and many more might be enumerated, are common to all cases of this description.⁶⁶⁴

The courts were also sometimes particularly sceptical of medical evidence, evidence based on opinion or theory which was provided for a fee. *Re D.O. Dyce Sombre, a Lunatic* is a case where medical evidence was approached with particular reserve:

Before I enter upon this part of the case, I beg that I may not be understood in what I have said or may say, as imputing to any of the physicians who signed the letter to me any intention to deceive me, or to suggest that they respectively do not honestly and sincerely entertain the opinions they have expressed. I have no doubt they do; but I have seen enough of professional opinions to be aware that in matters of doubt upon which the best constructed and best informed minds may differ, there is no difficulty in procuring professional opinions upon either side. If the question involves any theory or principle upon which the members of a profession are divided, the course is obvious; but upon any other subject of doubt, any person seeking for pecuniary advantage to obtain an object by managing, conducting and obtaining the favourable report of professional men will find no difficulty in procuring such favourable opinions.⁶⁶⁵

In this particular case, the scepticism was probably well-founded. The applicant had entered into a contract with a physician as medical advisor. The fee for services would be ten thousand pounds sterling if the case was successful, and two

⁶⁶² Doctors Bright and Southey. See *Re D.O. Dyce Sombre, a Lunatic* (1849), 1 Mac. & G. 116 at 120.

⁶⁶³ *Lovatt v. Tribe* (1862), 3 F. & F. 9 at 11.

⁶⁶⁴ *Evans v. Knight and Moore* (1822), 1 Add. 229 at 239.

⁶⁶⁵ *Re D.O. Dyce Sombre, a Lunatic* (1849), 1 Mac. & G. 116 at 128.

thousand pounds otherwise. The court found that a condition of this contract was the procurement of favourable medical opinions.⁶⁶⁶

This is perhaps an unusual case because of the amount of funds involved. Certainly in other cases, medical testimony is treated with respect. The evidence of the physicians retained by the court is accorded particular respect. Nonetheless, medical witnesses are not treated with any more respect than other witnesses.

Medical testimony was not accorded more weight than other witness' evidence, in part because medical knowledge and professional organization were in the process of formulation over the course of the century, and also in part because legal authority was in the ascendancy. We have seen that it was a time when legislation made a wide range of topics, including but by no means confined to lunacy, subjects of legal control. Social policy expressed in law became the fashion. The approach of the court in *Banks* provides an example of this trend. While the court certainly considers the medical treatises on insanity, it is also moved by the importance of the right to make a will, and the role of testamentary laws in civil society. The result is an approach which is not shaped by the diagnostic categories of the period or the opinions of medical professionals. The test in *Banks* refers to the perquisites for the specific legal task at hand, that is, to consider the subject property of the will and the natural heirs to the property. The standard of understanding and appreciation of the subject matter is similarly not based on medical standards, but is a legal standard that the court is able to apply.

The Twentieth Century

The closing years of the nineteenth century are the high water mark for the development of legal standards of competence in England, and the common law remains essentially unchanged since the nineteenth century. In the section of the most recent edition of Halsbury's which deals with the admissibility of evidence in a court determination of mental capacity, for example, only three of the forty-nine cases cited are from the twentieth century.⁶⁶⁷ One of those is from 1900; another is a general case on opinion evidence of a psychiatrist, which does not deal with issues specific to a competency determination at all.

⁶⁶⁶ *Re D.O. Dyce Sombre, a Lunatic* (1849), 1 Mac. & G. 116 at 126.

⁶⁶⁷ See Halsbury's *Laws of England*, (4th ed.), Lord Halsbury of St. Marylebone, (ed.), (London: Butterworths, 1960), Vol. 30, para. 1029 to 1038.

The reasons for the sudden decline in cases cannot be explained by reference merely to statutes and substantive law. Certainly, the 1890 revisions to the *Lunacy Act* significantly decreased the need for commencement of proceedings by way of commission in lunacy. That had never been a fertile ground of reported case law, however. The rules propounded by psychiatric institutions under the 1890 *Act* normally precluded the signing of documents by patients, and this fact, combined with increasing numbers of persons confined, may have reduced the case law to some degree. The rules did not normally preclude the signing of a will or codicil, however. The disappearance of cases regarding wills and regarding contracts made by persons not confined in institutions is a mystery.

Such cases as there are reflect in general the nineteenth century formulations of the law. The only twentieth century case frequently cited regarding capacity to make a will was *Battan Singh v. Amirchand*,⁶⁶⁶ which follows *Banks v. Goodfellow* closely. The testator was in the final stages of consumption, and was heard to have declared that he had no living relatives. In fact, he did have nephews living in India. Following *Banks* and other earlier wills cases, the court held that his unawareness of his natural family who had been the beneficiaries of previous wills, rendered the testator incompetent to make the will. The sole matter worthy of brief note is that the court makes no distinction in the case between lunacy as a function of delusion, mental defectiveness (formerly called idiocy), and general feeble-mindedness. The case involved the latter, but the cases relied on include cases of both traditional lunacy and idiocy.

The 1953 case of *In the Estate of Park, decd; Park v. Park*⁶⁶⁷ provides a further indication of how little had changed in the first half of the twentieth century. The testator had married shortly before his death. The same day, he executed a new will, leaving the bulk of his estate to his family, but leaving a small bequest to his new wife. The will was declared invalid under separate proceedings. His previous will would be revoked by the fact of his marriage. If the marriage was valid, therefore, the deceased in law would die intestate, and his new wife was to receive much of estate under the usual succession laws. It therefore became very important to discern whether or not the deceased had been competent to marry.

⁶⁶⁶ *Battan Singh v. Amirchand* [1948] A.C. 161 (J.C.P.C.—Fiji).

⁶⁶⁷ *In The Estate of Park, decd; Park v. Park* [1954] P. 112.

Following nineteenth century case law, the court held that the test for competence to marry involved whether a party was "capable of understanding the nature of the contract which he or she had entered into."⁶⁷⁰ Consistent with this case law, notwithstanding the formidable effects of marriage on one's powers over one's estate, it was held that the deceased had been competent to marry, even though he was not competent to make his will. Once again, there was no particularly significant advance on the nineteenth century law.

The one case which should be noted because it does substantially alter the nineteenth century law is *Re K, Re F*,⁶⁷¹ a case involving powers of attorney. According to the nineteenth century case law, a power of attorney was deemed to be revoked upon the incompetence of the donor of the power.⁶⁷² The theory would appear to be that the attorney was empowered only to do those acts which the donor was empowered to do, and when the principal became unable to act for himself or herself, the attorney became by definition unable to act for them. Following Ontario and other Canadian jurisdictions, England enacted a statutory exception to this common law rule in 1985.⁶⁷³ Under this exception, powers of attorney which specifically so provided could survive a subsequent finding of incompetence. At issue in the case was whether an individual had to be competent to manage his or her finances in order to sign such an enduring power of attorney.

According to the nineteenth century case law, the answer would surely have been that he or she would have to be so competent. The court in *Re K, Re F*, however, held that there were two separate standards of competence for these two purposes. The standard applicable to the signing of enduring powers of attorney was discussed in the following terms:

Finally I should say something about what is meant by understanding the nature and effect of the power. What degree of understanding is involved? Plainly one cannot expect that the donor should have been able to pass an examination on the provisions of the 1985 Act. At the other extreme, I do not think that it would be sufficient if he realised only that it gave cousin William power to look after his property. Counsel as *amicus curiae* helpfully summarised the matters which the donor should have understood in order that he can be said to have understood the nature and effect of the power: first,

⁶⁷⁰ at 121. Quoting *Boughton and Marston v. Knight* (1873), L.R. 3 P. & M. 64. The court also relied on *Browning v. Reane* (1812), 2 Phill. Ecc. 69; *Durham v. Durham* (1885), 10 P. 80; *Hunter v. Edney* (1881), 10 P. 93 and *Cole v. Cole* (1857), 5 Sneed 57 (Tenn.) for further elaboration of the test for competency to marry.

⁶⁷¹ *Re K, Re F* [1988] 1 All E.R. 358.

⁶⁷² See *Drew v. Nunn* (1879), 4 Q.B.D. 661, 40 L.T. 671 and cases following therefrom.

⁶⁷³ See *Enduring Powers of Attorney Act, 1985* (U.K.), 1985, c.29.

if such be the terms of the power, that the attorney will be able to assume complete authority over the donor's affairs; second, if such be the terms of the power, that the attorney will in general be able to do anything with the donor's property which the donor could have done; third, that the authority will continue if the donor should be or become mentally incapable; fourth, that if he should be or become mentally incapable, the power will be irrevocable without confirmation by the court. I do not wish to prescribe another form of words in competition with the explanatory notes prescribed by the Lord Chancellor, but I accept the summary of counsel as *amicus curiae* as a statement of the matters which should ordinarily be explained to the donor whatever the precise language which may be used and which the evidence should show he has understood.⁶⁷⁴

The deviation from the nineteenth century law is primarily in the understanding of the power of attorney. The phrasing of the test, quoted above, is reminiscent of the tests of competency of the nineteenth century, again indicating how little the law has changed.⁶⁷⁵

Such is a summary of the relevant case law on competency determination. Such development as there has been, and such statutory development as there has been, must of course be placed in some historical perspective.

Perhaps the most noticeable changes in the last hundred years for our purposes are the developments in clinical treatment and the change in status of the medical profession in general, and of the mental health professions in particular. It is easy to forget how recent a science medicine is. It is debatable prior to this century what effect medicine had on the death rate. In 1890, the life expectancy for males was forty-four years, less than ten years higher than it had been 250 years previously.⁶⁷⁶ The historical plagues prior to 1900, including typhoid, dysentery, and cholera, were by and large not conquered by medicine, but rather disappeared by natural abeyance. Porter makes a persuasive case that "Not until the coming of antibiotics in the 1940s did medicine possess the power reliably to save victims of infectious diseases from death."⁶⁷⁷ The development of effective treatments was in

⁶⁷⁴ at 363.

⁶⁷⁵ While not technically binding, this decision would be very persuasive to a Canadian court, and probably is good law in this country. On that assumption, it represents applicable statement of the test for capacity to appoint a substitute decision maker in this country.

⁶⁷⁶ R. Porter *Disease, Medicine and Society in England, 1550-1860* (Cambridge: Cambridge University Press, 1987) at 61. Porter cites Flinn, *The European Demographic System 1500-1820* (Brighton: Harvester Press, 1981) and Wrigley and Schofield, *The Population History of England, 1541-1871* (London: Edward Arnold, 1981) as the sources for these statistics. It has been argued that the vast bulk of even this relatively small change is related to changes in diet and nutrition, and a cleaner environment: V. McKeown, *The Rise of Population* (London: Edward Arnold, 1976), cited by Porter at 62.

⁶⁷⁷ Porter, *Disease, Medicine, and Society*, at 62.

part the result of much more sophisticated learning on medical issues. Medical professionals have increasingly been perceived by society as possessors of such knowledge, knowledge which the remainder of society does not have. The result has been increasing respect for the medical professional. The requirement that some medications would only be available by prescription from a doctor compounded the authority of doctors.

Nowhere are these results more clear than in the field of mental health. In 1883, Emil Kraepelin, working in Munich, published his classification of psychiatric disorders, a classification which apparently continues to be the basis of taxonomy used in the United States.⁶⁷⁸ The category called *dementia praecox*, later somewhat expanded under the name schizophrenia, dates from this period. The classification system has of course been much expanded since that time, and has become much more detailed. The work of Freud and his successors in psychology created a minor revolution of its own. The result of all this taxonomy was much wider diagnosis of mental illness.

New treatments were developed. Sodium amylal was employed for the treatment of acute neurosis in the thirties. Electro-convulsive therapy and insulin shock treatments became wide-spread in the mid-1930s and early 1940s. The first modern tranquilizers were introduced in the early 1950s, and the first anti-depressants were introduced a few years later. Neuroleptic medications became common in the 1960s and 1970s, creating the promise that mental illness, as lunacy was now called, could be treated.

There was a corresponding change in the perception and character of institutions for the mentally ill. Notwithstanding the developing conceptions of treatment in psychiatric asylums in the nineteenth century, Victorian asylums were perceived as a way of moving people away from society, a method of social control. With insignificant exceptions, it was not until 1930 that English psychiatric facilities could accept voluntary patients.⁶⁷⁹ Prior to that time, all patients were committed. Throughout the nineteenth century, through the development of court procedures and administrative processes, the law had entered the psychiatric asylum to ensure standards and to ensure that the persons contained in those asylums were

⁶⁷⁸ W. Overholser "An Historical Sketch of Psychiatry" (1949) Rpt. Allen, Ferster and Rubin, *Readings in Law and Psychiatry* (Baltimore: Johns Hopkins Press, 1968) 3 at 8.

⁶⁷⁹ See *Mental Treatment Act, 1930*, 20/21 George V, c.23, s.1. This Act also contains the first references to out-patients: see s.6(3)(a).

appropriately committed. By 1890, admission to asylums and madhouses was only by order of a justice.

As the twentieth century progressed, perceptions began to change. Mental health facilities were thought of increasingly as health facilities, rather than merely places of confinement. Their operation was absorbed into the National Health with the introduction of that scheme just after the Second World War. The views of the Percy Commission, which reported in 1957, express the more modern attitudes to psychiatric facilities:

Mental disorders are forms of ill-health, and care and treatment are usually based on medical diagnosis and advice. This may be given by a general practitioner, a specialist in psychiatry, or a doctor working in the school health service or for the local health authority. In the past treatment was mainly institutional, but now a great deal of medical treatment and social care is given to mentally ill and mentally defective patients while they continue to live and work in the general community. ... More mentally ill patients now attend psychiatric clinics as out-patients each year than are admitted for in-patient treatment, not to mention the still larger number of patients with milder forms of illness who are treated by general practitioners. In the past the state's primary duty towards mentally disordered patients was considered to be their compulsory detention for care and custody. This view is now out of date, as in present conditions most patients could be given care or treatment without using compulsory powers. But the idea that treatment involves detention still underlies much of the present law, and for some types of patient the law operates to prevent hospital in-patient treatment except with powers of detention. This is one of the main reasons why the law now needs revision.⁶⁰⁰

As the first half of the century progressed, the number of persons committed climbed from approximately 100,000 to over 150,000.⁶⁰¹ Where in 1890, 29.26 persons per 10,000 population were officially recognized as insane,⁶⁰² in 1954 alone, there were 140 men actually admitted to facilities per 100,000 male population and 182 women admitted per 100,000 female population.⁶⁰³ In addition to the 150,000 admissions to facilities, roughly 122,000 people per year attended facilities' as out-patients at this period.⁶⁰⁴

⁶⁰⁰ Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, *Report* by E.S. Campbell, Baron Percy of Newcastle (London: Queen's Printer, 1957) at 27 f.

⁶⁰¹ R. Porter *A Social History of Madness*, at 20. See further Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, *Report* by E.S. Campbell, Baron Percy of Newcastle (London: Queen's Printer, 1957) at Appendix 4.

⁶⁰² B. Hoggett *Mental Health Law*, (2nd ed.), (London: Sweet and Maxwell, 1984), at 6.

⁶⁰³ Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, *Report* by E.S. Campbell, Baron Percy of Newcastle (London: Queen's Printer, 1957) at Appendix 4, page 310.

⁶⁰⁴ Great Britain, Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, *Report* by E.S. Campbell, Baron Percy of Newcastle (London: Queen's Printer, 1957) at Appendix 4, page 312. This statistic refers to persons attending as out-patients for diagnosis or commencing treatment, in the year 1955.

As the Percy Commission notes, by the middle of the twentieth century, the law was perceived as being increasingly out of step with the times. As a result of its report, the first comprehensive amendments to the 1890 *Act* became law in 1959.⁶⁶⁵ Judicial sanction was no longer needed prior to an individual being civilly committed. Instead, a review board would review the committals upon application by the person committed. The review board was composed of doctors and lay persons, and would not be subject to appeal. This system remained essentially intact when the *Act* was revised in 1983.⁶⁶⁶ Similarly, much of the highly regulatory substance of the 1890 *Act*, restricting physical restraint and regulating patient diet, for example, was removed in the 1959 *Act*. The attitude of the Percy Commission was in one sense to break down the walls of the establishment, by creating a more flexible system, accounting for the possibility of community care. Within the facilities themselves, however, the role of legal checks of authority was perceived as much more minimal than had been the case seventy years earlier. Again, there was little to amend this perception in the 1983 revisions to the *Act*.

There have, therefore, been three significant statutory frameworks in effect in England in this century. The matters of concern to the Enquiry are not dealt with consistently under the three *Acts*.

The provisions concerning competence to manage one's estate are most clearly defined in the *Acts*. The 1890 *Act* combined and consolidated both the processes for committeehip and the law regarding asylums and madhouses into one statute. Under the terms of that *Act*, unlike its predecessors, the court control over estates extended not merely to persons found lunatic by inquisition, but also to all persons confined in lunatic asylums, and, specifically, to persons incapable of managing their affairs by reason of age or disease. Simplified procedures continued to be available for persons with small estates.⁶⁶⁷ The criteria of the inquisition in lunacy was as it had always been: "whether a person is of unsound mind and incapable of managing himself and his affairs."⁶⁶⁸ While there were some minor

⁶⁶⁵ *Mental Health Act, 1959*, 76 Elizabeth II, c.72.

⁶⁶⁶ *See Mental Health Act, 1983* (U.K.), 1983, c.20.

⁶⁶⁷ *Lunacy Act, 1890* (U.K.), 53 Victoria, c.5, s.116.

⁶⁶⁸ s.90(1).

amendments particularly with reference to the powers of committees in the early twentieth century,⁶⁰⁰ this was the essentially the state of the law to 1959.

The 1959 *Act* made several significant changes. Firstly, the old procedure of a commission in lunacy by inquisition was abolished. The new process was outlined in section 101 of the 1959 *Act*:

101. The functions of the judge under this Part of this *Act* shall be exercisable where, after considering medical evidence, he is satisfied that a person is incapable, by reason of mental disorder, of managing and administering his property and affairs; and a person as to whom the judge is so satisfied is in this Part of this *Act* referred to as a patient.⁶⁰¹

The right to a trial by jury is gone, and the new process involves a simple application to a judge. The reference to medical evidence is indicative of the rise in status of medical professionals over the first half of the century. It was not a controversial provision; it had been the practice of inquiries well before this time to require such medical evidence prior to reaching a determination. "Mental disorder" was also a defined term in the *Act*:

4 (1) In this *Act* "mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder, and any other disorder or disability of the mind; and "mentally disordered" shall be construed accordingly.

The 1959 *Act* represents a departure for two reasons. Firstly, the automatic loss of control by persons committed to psychiatric facilities over their estates, introduced by the 1890 *Act*, was abolished. Persons in psychiatric facilities were treated in law no differently than persons in society as a whole. Secondly, the complicated procedures associated with the inquisition in lunacy were abolished, and a simple process of application to a single judge introduced.⁶⁰²

The 1983 *Act*, once again, made no essential changes to the processes or criteria used by the courts, although some of the procedural matters were removed from the statute and placed into court rules. In addition, the matter may now be considered by a master, rather than a judge of the Court of Protection.

⁶⁰⁰ See *Lunacy Act, 1900* (U.K.), 8 Edward VII, c.47; *Lunacy Act, 1922* (U.K.), 12/13 George V, c.60.

⁶⁰¹ *Mental Health Act, 1959* (U.K.), 7/8 Elizabeth II, c.72, s.101. This wording is repeated in the 1983 revision to the statute: see *Mental Health Act, 1983* (U.K.), 1983, c.20, s.94 (2).

⁶⁰² Procedures in Ontario were simplified somewhat earlier, by decree: see discussion of Ontario statutes, *infra*.

There is a startling paucity of case law or useful secondary work regarding the interpretation of the sections involving the determination of competency. An indication of how underdeveloped the concepts are is the fact that the leading practitioner's manual on practice in the Court of Protection does not discuss the point at all.⁶⁰⁰

As regards personal guardianship, the only process contained in the 1890 *Act* is the commission in lunacy. With the abolition of the commission process in 1959, a new process was introduced. Unlike the commission process, it was not related to the process regarding competence to manage the estate. Its procedures instead paralleled the committal powers of the 1959 *Act*, as a way of ensuring some control over individuals not admitted to psychiatric facilities, or alternatively upon discharge from psychiatric facilities.

The theory of the 1959 *Act* was simple. Persons with mental disorders who required detention for their own health and safety or the protection of other persons were to be detained for observation in psychiatric hospitals. Persons with serious mental disorders who required detention for their own health and safety or the protection of others were to be detained for treatment. Persons who did not require detention for their own health and safety or the protection of others were not to be placed in hospital, but if they had a particularly serious mental disorder, they should have a guardian.⁶⁰¹ The appointment of a guardian voided any civil committal of the individual.⁶⁰² While it was not explicit in the legislation that a voluntary patient in a hospital could not be subject to a guardianship order, this was not the situation for which the guardianship order was designed. Consistent with this, application was to the local health authority, who could be made the guardian, or, if someone other than the authority was appointed, had to approve the guardian.⁶⁰³

To carry this scheme into effect, the *Act* subdivided "mental disorder" as defined by the *Act* and as cited above, into four categories:

⁶⁰⁰ Heywood and Munnery, *Court of Protection Practice*, (11th ed.), N.A. Whitehorn, (ed.), (London: Stevens and Sons, 1985).

⁶⁰¹ *Mental Health Act, 1959* (U.K.), 7/8 Elizabeth II, c.73, ss. 25, 26, 33.

⁶⁰² *Mental Health Act, 1959* (U.K.), 7/8 Elizabeth II, c.73, s.34(6).

⁶⁰³ s.33 (3).

- 4 (2) In this *Act* "severe subnormality" means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of age to do so.
- (3) In this *Act* "subnormality" means a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.
- (4) In this *Act* "psychopathic disorder" means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.⁶⁹⁶

The fourth category, "mental illness", was not defined by the *Act*.

Absent a criminal conviction, the guardianship provisions applied to persons suffering from "mental illness or severe subnormality", and to persons under the age of twenty-one suffering from psychopathic disorders or subnormality, when it was "necessary in the interests of the patient or for the protection of other persons that the patient should be" received into guardianship.⁶⁹⁷ The guardianship order conferred on the guardian "all such powers as would be exercisable by them or him in relation to the patient if they or he were the father of the patient and the patient were under the age of fourteen years."⁶⁹⁸ This would have been taken to include virtually all personal decisions, including place of habitation and treatment decisions.⁶⁹⁹

There is little case law to explain these provisions further. Consistent with section 4(5) of the 1959 *Act*, it has been held that sexual attraction to minors does not of itself constitute a mental disorder,⁷⁰⁰ and such an attraction can therefore not be used to justify an individual being made the subject of a guardianship order. The term "mental illness" has never been adequately defined. The only judicial discussion of the term, in *W. v. L.*, does not particularly clarify matters:

⁶⁹⁶ *Mental Health Act, 1959* (U.K.), 7/8 Elizabeth II, c.72, s.4(2) to 4(4).

⁶⁹⁷ Section 33(2).

⁶⁹⁸ section 34 (1).

⁶⁹⁹ Regarding presumptions of competence based on age, see *infra*. It is not entirely clear that the effect of this clause would today be as broad as was no doubt understood at the time.

⁷⁰⁰ *R. v. Mental Health Review Tribunal, ex parte Clarworthy*, [1985] 3 All E.R. 699 (Q.B.D.). The case was actually decided under section 1(3) of the 1983 *Act*, which is identical to section 4(5) of the 1959 *Act*.

The words are ordinary words of the English language. They have no particular medical significance. They have no particular legal significance. How should the court construe them? The answer in my judgment is to be found in the advice which Lord Reid recently gave in *Cozens v. Bruns* [1973] A.C. 854, 861, namely, that ordinary words of the English language should be construed in the way that ordinary sensible people would construe them. That being, in my judgment, the right test, then I ask myself, what would the ordinary sensible person have said about the patient's condition in this case if he had been informed of his behaviour to the dogs, the cat and his wife? In my judgment such a person would have said: "Well, the fellow is obviously mentally ill." If that be right, then, although the case may fall within the definition of "psychopathic disorder" in section 4(4), it also falls within the classification of "mental illness"; and there is the added medical fact that when the EEG was taken there were indications of a clinical character showing some abnormality of the brain. It is that application of the sensible person's assessment of the condition, plus the medical indication, which in my judgment brought the case within the classification of mental illness and justified the finding of the county court judge.⁷⁰¹

Hoggett, rather disparagingly but with some justification, speaks of this as the "man-must-be-mad" test.⁷⁰² She is perfectly right, however, that it does little to assist in understanding the level of illness which is required for an individual to warrant a guardianship order.

The 1983 *Act* did little to amend these provisions. "Mental illness" remained an undefined term. The terms "severe subnormality" and "subnormality" were replaced respectively with "severe mental impairment" and "mental impairment" respectively, and a severe impairment of social functioning was required as well as severe impairment of intelligence. In addition, both required that the mental disorder be "associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned".⁷⁰³ This was apparently a compromise reached after lobbying efforts by advocates of persons labelled mentally disordered for their own statute and set of criteria.⁷⁰⁴ The result is a hole left in the guardianship provisions for persons whose abilities are such that they require assistance, but who are not violent.

The 1983 *Act* also limited the authority of guardians. Rather than the general quasi-parental powers previously granted to the guardian, the guardian now has three major powers: to require the individual to reside at a specified place; to require the individual to attend at specified places and times for the purposes

⁷⁰¹ *W. v. L.*, [1974] 1 Q.B. 711 (C.A.) at 719.

⁷⁰² B. Hoggett *Mental Health Law*, (2nd ed.), (London: Sweet and Maxwell, 1984) at 46.

⁷⁰³ *Mental Health Act*, 1983 (U.K.), 1983, c.20, s.1(2).

⁷⁰⁴ See Hoggett at 53.

of medical treatment, occupational or other training, or education; and to require that access to the patient be given to social workers and specified medical professionals.⁷⁰⁵ It is at least arguable that the guardian does not have authority to consent to the treatment on behalf of the patient, however, should the patient refuse the treatment.⁷⁰⁶

As regards treatment specifically, the *Acts* prior to 1983 did not address consent issues. It appears to have simply been understood that once the patient arrived at the hospital, treatment would occur. This presumption is particularly compelling regarding persons admitted under section 26 of the 1959 *Act*, where people with serious disorders could be admitted specifically for the purposes of treatment. By comparison, persons with less serious disorders admitted under section 25 were admitted and detained for observation only. Presumably, the individuals admitted under section 25 did not lose their right to consent to treatment. The case does not appear to have been made, however, and there is no case law of assistance under this *Act*.

Under the 1983 *Act*, patients in psychiatric facilities in general have no right to refuse psychiatric treatment, if the treatment is prescribed by the patient's doctor.⁷⁰⁷ There are two exceptions to this general rule. Specified treatments, most notably electro-convulsive therapy, can only be administered with the consent of the patient or upon certification by another doctor that "having regard to the likelihood of its alleviating or preventing a deterioration of [the patient's] condition, the treatment should be given."⁷⁰⁸ Psycho-surgery requires both the consent of the patient and the second medical opinion.⁷⁰⁹ Presumably, persons outside psychiatric facilities have the same rights to consent to treatment as other people do. There are no cases of assistance as to the standard of competency required for consent to treatment, however.

Pursuant to the law regarding competence to appoint a substitute decision maker, reference has already been made to the case of *Re K, Re F*. There does not appear to be further useful jurisprudence on this topic. Similarly, there does

⁷⁰⁵ See Hoggett at 303.

⁷⁰⁶ See Hoggett at 303.

⁷⁰⁷ *Mental Health Act, 1983* (U.K.), 1983, c.20, s.63.

⁷⁰⁸ Section 58(3).

⁷⁰⁹ Section 57.

not appear to be jurisprudence specifically on the issue of competence to disclose the clinical record.

Apart from the issues surrounding durable powers of attorney, the twentieth century English law is of relatively little assistance in elucidating the meaning of Ontario law. The conception of guardianship has been altered in England, to represent a less intrusive form of committal. The requirement for consent prior to treatment has been largely done away with for persons within the purview of the *Mental Health Act*. While the four stages of mental disorder prescribed in the English statute provide formulations against which the Enquiry may juxtapose its thoughts, they are not directly on point. They are designed to serve in part as a basis of committal criteria, and they reflect the lack of a consent requirement in matters of treatment, and the different conception of guardianship.

Age, Presumptions, and Competence

The issue of age arises in matters of competency at both ends of the spectrum: the elderly may be deemed incompetent because of age; and children may be deemed incompetent because of immaturity.

As has already been explained, the role of an inquisition in lunacy expanded at the beginning of the nineteenth century to include persons who, while not lunatics in the technical sense of the period, had become incompetent to manage their affairs.⁷¹⁰ By 1818, however, it had been determined that old age in and of itself did not give rise to any presumption of incapacity.⁷¹¹ This continues to be the case.

The *National Assistance Act, 1948*⁷¹² does provide some mechanisms akin to guardianship, and the subjects of applications under this *Act* are apparently almost universally elderly. An application under the *Act* will be granted if it is demonstrated (1) that the individual is either suffering from grave chronic disease or, being aged, infirm or physically incapacitated, is living in insanitary conditions; and (2) that the person is unable to care for themselves, and is not receiving from other persons, proper care and attention; and (3) that removal from home is

⁷¹⁰ See *Ex parte Crumner* (1806), 12 Ves. Jun. 445; *Ridgeway v. Darwin* (1802), 8 Ves. Jun. 65.

⁷¹¹ *Kinleside v. Harrison* (1818), 161 E.R. 1196.

⁷¹² *National Assistance Act, 1948* (U.K.), 11/12 George VI, c.29.

necessary, either in the interests of the individual or to prevent injury to the health of, or serious nuisance to, other persons.⁷¹³

It is unclear how much this *Act* is used. It is further unclear what the effect of an order under the *Act* is. It certainly allows the removal of the individual from his or her home, for the provision of "the necessary care and attention"; it is not clear how it affects the civil rights of the individual beyond that. It is theoretically consistent, for example, that the individual would be taken to hospital for treatment, but would refuse treatment. This issue does not appear to be addressed by the *Act*. As was the case with the 1959 *Mental Health Act*, it would appear that the legislators assumed that the only problem requiring action was getting the individual to a hospital or other facility. Because of these conceptual limitations, the *Act* is of limited assistance to our Enquiry in clarifying the nature of competency.

There is more case law regarding the capacity of persons who have not attained the age of majority, although once again, the application of those principles to the issues before the Enquiry is somewhat problematic. The English case law has tended to focus on the right of a minor to be free of parental control, rather than the assessment of competence. The classic nineteenth century case in this regard is *In re Agar-Ellis; Agar-Ellis v. Lascelles*.⁷¹⁴ That case involved a battle between a Protestant father and his estranged Catholic wife, over visiting rights regarding their sixteen year old daughter. The daughter was in the custody of the father, and the father wished to limit exposure to the wife. The court held:

Now I cannot accede to the argument thus put forward. It seems to me to be directly contrary to the law of England, which is, that the father has the control over the person, education, and conduct of his children until they are twenty-one years of age. That is the law.⁷¹⁵

The court did acknowledge that upon attaining the age of consent, which had been arbitrarily set regarding place of habitation at fourteen for boys and sixteen for girls, a child who had left parental control could no longer be restored to parental control by court process, but for persons such as the daughter who remained within

⁷¹³ Section 47.

⁷¹⁴ *re Agar-Ellis; Agar-Ellis v. Lascelles* (1883), 24 Ch. D. 317 (C.A.).

⁷¹⁵ at 326.

parental control, the court said "They can object, or they can submit. But they cannot consent."⁷¹⁶

This case obviously reflects the views regarding family life in England during that period. The court finds that "The rights of a father are sacred rights because his duties are sacred duties",⁷¹⁷ and that "the Court must not be tempted to interfere with the natural order and course of family life, the very basis of which is the authority of the father".⁷¹⁸

This line of cases was called into doubt in 1969, in the case of *Hewer v. Bryant*.⁷¹⁹ Denning M.R., in his typical style, spoke for the majority in rejecting *Agar-Ellis* in the following terms:

I would get rid of the rule in *In re Agar-Ellis* and of the suggested exceptions to it. That case was decided in the year 1883. It reflects the attitude of a Victorian parent towards his children. He expected unquestioning obedience to his commands. If a son disobeyed, his father would cut him off without a shilling. If a daughter had an illegitimate child, he would turn her out of the house. His power only ceased when the child became 21. I decline to accept a view so much out of date. The common law can, and should, keep pace with the times. It should declare, in conformity with the recent Report of the Committee on the Age of Majority, that the legal right of a parent to the custody of a child ends at the 18th birthday: and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, and the more so the older he is. It starts with a right of control and ends with little more than advice.⁷²⁰

This was again a case which essentially concerned custody. It concerned the right of a child to commence litigation relating to injuries suffered in a motor vehicle accident. If the child were in parental control, the action would have been statute barred. The court held that the child had left parental control at age fifteen, and therefore could sue in his own right at that time.

More closely on point but also problematic is the case of *Gillick v. West Norfolk and Wisbech Area Health Authority and Another*.⁷²¹ That case concerned the prescription of birth control pills to a woman aged fifteen. The fact that the

⁷¹⁶ *Ibid.*

⁷¹⁷ *Ibid* at 329.

⁷¹⁸ *Ibid* at 335.

⁷¹⁹ *Hewer v. Bryant* [1970] 1 Q.B. 357 (C.A.).

⁷²⁰ *at* 369.

⁷²¹ *Gillick v. West Norfolk and Wisbech Area Health Authority and Another* [1985] 3 All E.R. 402 (H.L.).

subject matter of this case was so controversial causes some concerns regarding its application, and the fact that the five judges hearing the case each wrote a judgment does nothing to ease the interpretation, but the comments of the court do support the notion that there is no fixed age at which an individual becomes competent.

Lord Fraser of Tullybelton found no statutory impediment to persons under the age of sixteen years consenting to contraceptive advice, examination, and treatment, "provided she has sufficient understanding and intelligence to know what they involve."⁷²² He continued:

It is, in my view, contrary to the ordinary experience of mankind, at least in Western Europe in the present century, to say that a child or a young person remains in fact under the complete control of his parent until he attains the definite age of majority, now 18 in the United Kingdom, and that on attaining that age he suddenly acquires independence. In practice most wise parents relax their control gradually as the child develops and encourage him or her to become increasingly independent. Moreover, the degree of parental control actually exercised over a particular child does in practice vary considerably according to his understanding and intelligence and it would, in my opinion, be unrealistic for the courts not to recognise these facts. Social customs change, and the law ought to, and does in fact, have regard to such changes when they are of major importance.⁷²³

The passage from Lord Denning cited above is then quoted with approval. His Lordship then finds that the issue of parental involvement is related to the best interests of the child. Normally, it would be appropriate to involve the parents in a discussion of the treatments proposed. The parent did not have a veto power, however.

Lord Scarman indicated the issue for consideration arises when the parent loses the right to consent on behalf of the child for medical treatment. He states:

The underlying principle of the law was exposed by Blackstone and can be seen to have been acknowledged in the case law. It is that parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision.

• • •

In light of the foregoing I would hold that as a matter of law the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what

⁷²² at 409 f.

⁷²³ at 410 f.

is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law.⁷⁵¹

Lord Bridge of Harwich decided on other grounds, but concurred in the reasons of Lords Scarman and Fraser. Lord Brandon of Oakbrook also decided on other grounds, being of the view that the provision of birth control to women under sixteen condoned sexual activity with such women, and as such, was in violation of public policy.

Lord Templeman's decision is also more concerned with contraception than with competence, however, his decision does reflect a certain understanding of the competency issue. He states that the parent having custody of the child has authority to decide matters which the infant is not competent to decide upon. His Lordship continues:

I accept also that a doctor may lawfully carry out some forms of treatment with the consent of the infant patient and against the opposition of a parent based on religious or any other grounds. The effect of the consent of the infant depends on the nature of the treatment and the age and understanding of the infant. For example, a doctor with the consent of an intelligent boy or girl of 15 could in my opinion safely remove tonsils or a troublesome appendix. But any decision on the part of a girl to practise sex and contraception requires not only knowledge of the facts of life and of the dangers of pregnancy and disease but also an understanding of the emotional and other consequences to her family, her male partner and to herself. I doubt whether a girl under the age of 16 is capable of a balanced judgment to embark on frequent, regular or casual sexual intercourse fortified by the illusion that medical science can protect her in mind and body and ignoring the danger of leaping from childhood to adulthood without the difficult formative transitional experiences of adolescence. There are many things which a girl under 16 needs to practise but sex is not one of them.⁷⁵²

While His Lordship dissents in the eventual judgment, it does appear that he too supports the concept of a flexible age of consent for medical treatment, based on abilities of the individual concerned. His disagreement lies with the concept that a fifteen year old girl could ever be competent to engage in sexual activity.

Gillick is the leading case in the English tradition regarding competence and age. All four of the judges expressing an opinion on the point agree that a firm age of consent no longer applies. This may be taken as the law in England as regards competency to consent to treatment, and it also reflects the current state of Ontario common law. Indeed, in a refreshing reversal of the usual case, Ontario case law is relied upon by the English court in reaching its conclusion.

⁷⁵¹ at 421 ff.

⁷⁵² at 432.

IV. HISTORICAL DEVELOPMENTS IN U.S.

Wills, and Contracts

The United States inherited the English law regarding lunacy as it existed up to the mid-eighteenth century. At the time of the revolution, the powers of the Lord Chancellor, including the powers regarding inquisitions in lunacy, were transferred to the state courts of Chancery. Contractual and testamentary law were also subsumed mainly into the jurisdiction of the state governments rather than the federal government, so that state courts also inherited the existing common law from the English courts.

This situation poses some problems for a general discussion of American law in these areas. Fifty states and the District of Columbia now deal with these issues. Statutory frameworks of the issues have developed differently in the various jurisdictions, and the views of state courts differed as to applicable principles of common law. Different state constitutions affected the form and substance of permissible state intervention into the rights of individuals. Whether a jury trial was necessary for an inquisition in lunacy, for example, is not consistent in all states as a result of different provisions of state constitutions.⁷²⁶ In some states, evidence of incompetence is to be proven according to the criminal standard of evidence;⁷²⁷ in others, a high civil standard of "clear and convincing" proof is determinative.⁷²⁸ Complete uniformity can therefore not be expected, making detailed discussion difficult. Nonetheless, with this caveat, the general principles of American law regarding civil competency may be discussed.

The American courts tended to adopt the English law as it existed at the time of the revolution. Persons were presumed sane and competent unless the contrary was shown. Evidence that an individual was incompetent did not affect the validity of a deed or contract when the document was executed during a lucid interval unless the individual had been found a lunatic by inquisition prior to the execution of the document. By the early nineteenth century, "lunacy" or "idiocy", within the strict legal meanings of those terms, did not need to be shown, and incompetence could be based on feebleness, physical illness, old age, or other cause. The uncertainty, finally settled in English law by *Banks v. Goodfellow*

⁷²⁶ Compare *In Re McLaughlin*, 62 S.W. 2d 410 (1933, S.C.Mo.) with *Reid v. Reid*, 118 S.W. 2d 150 (1938, Ky. C.A.).

⁷²⁷ See, for example, *Denison v. Commonwealth of Kentucky*, 383 S.W. 2d 681 (Ky., 1964).

⁷²⁸ See, for example, *Micco v. Replegle*, 53 P. (2d) 1093 (Okla., 1935); *Layman v. Bennett*, 61 N.E. 2d 624 (Ohio, 1944); *In Re Boyer*, 636 P. 2d 1085 (Utah, 1981).

discussed above, as to the existence of "partial insanity", being sane on some subjects and not others, was not reflected in American law, in which partial insanity was always recognized by the courts.⁷²⁹

American law developed more slowly than did English law in the early years of the nineteenth century. Furthermore, the English development of the law of competency determination was essentially complete by the end of the nineteenth century, and modern English cases are few, and where they do exist, are not on point or particularly significant. American case law regarding testamentary and contractual capacity was also based on nineteenth century principles. Unlike English law, the issues have continued to be litigated throughout the twentieth century, although truly leading cases are less prevalent after the Second World War. The historical framework is therefore different. Where English law regarding competency determination developed in the context of renewed social conscience, social awareness and prior to the abdication of the field of mental health to medical professionals, American law regarding competency determination developed in a more libertarian political climate, at a period when the medical model was increasingly in control of health issues in general, and mental health and psychiatric patients in particular.

American law did diverge from the principles established in English law on a number of important issues. As has been discussed, the English case law as it developed in the nineteenth century centred on delusion as the hallmark of lunacy. The effect of the philosophy of John Locke on the English court has been noted. Whether by historical accident or philosophic choice, the leading American cases of the early and mid nineteenth century did not deal primarily with delusional people. Instead, the leading cases dealt, by and large, with persons whose competency was in doubt as a result of severe physical illness, old age, or developmental limitations. As a result, where English courts developed ornate doctrine regarding delusions, the American jurisprudence developed to accommodate people of limited abilities.

The American doctrines concerning validity of wills demonstrates the similarity to and the divergence from English law. The case of *Harrison v. Rowan*, decided in 1820, provides the following definition of competency in testamentary matters:

⁷²⁹ See, for example, *Hall v. Unger*, 4 Sawyer 672 (1867, Circ. Ct. Cal.) and *Mandley v. Staples*, 19 A. 893.

As to the testator's capacity. He must, in the language of the law, have a sound and disposing mind and memory. In other words, he ought to be capable of making his will, with an understanding of the nature of the business in which he is engaged; a recollection of the property he means to dispose of, and of the persons who are the objects of his bounty, and the manner in which it is to be distributed between them. It is not necessary that he should view his will with the eye of a lawyer, and comprehend its provisions in their legal form. It is sufficient, if he has such a mind and memory as will enable him to understand the elements of which it is composed – the disposition of his property in its simple forms. It is the business of the testator to dictate the purposes of his mind; and of the scrivener to express them in legal form.⁷²⁸

Two years later, the same judge commented:

He [the testator] must, in the language of the law, be possessed of a sound and disposing mind and memory. He must have memory. A man in whom this faculty is totally extinguished cannot be said to possess understanding to any degree whatever or for any purpose. But his memory may be very imperfect; it may be greatly impaired by age or disease ... The question is not so much what was the degree of memory possessed by the testator as this: Had he a disposing memory? Was he capable of recollecting the property he was about to bequeath; the manner of distributing it; and the object of his bounty? To sum up the whole in the most simple and intelligent form: Were his mind and memory sufficiently sound to enable him to know and to understand the business in which he was engaged, at the time when he executed his will?⁷²⁹

On the one hand, these comments are unremarkable. They are reminiscent of nineteenth century English idiocy cases discussed elsewhere, including *Bannatyne and Bannatyne v. Bannatyne*⁷³² and *Kinleside v. Harrison*.⁷³³ What is remarkable is that this standard was applied to delusional people, lunatics, in the United States by the middle of the nineteenth century.⁷³⁴ Such an approach would have been very unlikely in England at the period.

The effect of the failure to centre on delusion in determination of incompetency may be seen in the different framework adopted for enforcement of the contracts executed by persons who were incompetent but not subject to committeehip. Subject to various exceptions not relevant for the present discussion, the English rule was and is that contracts made by such a person were enforceable unless the other party was actually aware or ought reasonably to have

⁷²⁸ *Harrison v. Rowan*, 3 Wash. 580 (N.J., 1820).

⁷²⁹ *Sirvins v. Vancleve*, 4 Wash. 262 (N.J., 1822). Emphasis in original.

⁷³⁰ (1852), 2 Rob. Ec. 472.

⁷³¹ (1818), 161 E.R. 1196.

⁷³⁴ See, for example, *Turner v. Hand*, 3 Wallace Jr. 68 (Penn., 1835).

been aware of the incompetence.⁷⁷⁵ The American rule developed two standards: Contracts made by an individual who was incompetent were generally void⁷⁷⁶ and knowledge of the other party was not normally a requirement for the incompetent person to avoid the enforcement of the contract. Contracts executed by persons of marginal competence were not void, but rather voidable. The marginally competent individual could escape the enforcement of the contract if and only if undue influence had been exerted upon him or her.⁷⁷⁷ This dual standard had been introduced into the law of wills by 1889.⁷⁷⁸

As a result, only those contracts executed by individuals of the most minimal abilities were considered void *ab initio*. The rationale for this approach is explained in the case of *Blanchard v. Nestle*:⁷⁷⁹

There is no grade of understanding, between the highest and lowest, which incapacitates the testator, when there is no fraud or imposition. In the language of Senator Verplank, "to establish any standard of intellect or information beyond the possession of reason in its lowest degree, as in itself essential to legal capacity, would create endless uncertainty, difficulty and litigation, would shake the security of property, and wrest from the aged and infirm that authority over their earnings or savings which is often their best security against injury and neglect. If you throw aside the old common-law test of capacity, then proofs of wild speculations or extravagant and peculiar opinions or of the forgetfulness or the prejudices of old age might be sufficient to shake the fairest conveyance, or impeach the most equitable will. The law, therefore, in fixing the standard of positive legal competency, has taken a low standard of capacity; but it is a clear and definite one, and therefore wise and safe. It holds (in the language of the latest English writer on this subject), that "weak minds differ from strong ones only in the extent and power of their faculties; but unless they betray a total loss of understanding, or idiocy, or delusion, they cannot properly be considered unaccount."

⁷⁷⁵ See for example *Brymer v. Ashwell* (1827) 1 Mood. & M. 105, *Howard v. Digby* (1834), 2 Cl. & Fin. 643, and *Bauer and Oiler v. Earl of Portsmouth* (1826), 5 B. & C. 170, *The Imperial Loan Co. Ltd. v. Stone*, [1892], 1 Q.B. 599, *York Glass Co. Ltd. v. Hubb* (1925), 134 L.T. 36. The chief exception to the general rule cited here concerned "contracts for necessities", an exception which also exists in American law.

⁷⁷⁶ See, for example, *Hinder v. Board*, 42 N.E. 1030 (Ohio, 1896); *Fleming v. Consolidated Sales Co.*, 240 P. 376 (Montana, 1925) and the cases cited therein.

⁷⁷⁷ See, for example, *Tate v. Murphy*, 217 P. 2d 177 (Olin., 1949); *Hanks v. McNeil Coal Corporation*, 168 P. 2d 256 (Cal., 1946); *Patz v. Stephens*, 198 P. 712 (Ariz., 1921); *Winson v. Malcolm* 106 N.E. 211 (Ill., 1914); *Kilgore v. Cross and Diver*, 1 McCrery 144, (Ariz., 1880); *Allure v. Jewell*, 94 U.S. 506 (Mich., 1876); *Conner v. Sunday*, 14 P. 306 (Cal., 1887); *Campbell v. Campbell*, 2 N.W. 540 (Iowa, 1879) and cases cited therein.

⁷⁷⁸ See *Reichsbarth v. Raddach*, 18 A. 432 (Penn., 1889).

⁷⁷⁹ 2 Denis 37; cited in *Fleming v. Consolidated Motor Sales Co.*, 240 P. 376 at 382 f. The precise date of the *Blanchard* case is not provided in the *Fleming* case.

As to the specifics of the standard, and again relying on the *Blanchard* case, *Fleming* refers to "a total want of understanding" as the appropriate standard.⁷⁴⁰ This want of understanding need not extend to all areas of the person's mind, but merely "such a degree of mental deficiency as to render him incapable of understanding a transaction of the nature involved."⁷⁴¹ A standard formulation of this level of understanding is contained in the following passage from *Buuck v. Kruckeberg*:⁷⁴²

The test of mental capacity to make a deed is that the grantor shall have sufficient mind and memory to comprehend the nature and extent of his act and to understand the nature of the business in which he is engaged and to exercise his own will in reference thereto.

Other cases specifically adopt a less strict standard than *Buuck*. *Blochowitz v. Blochowitz*, for example, refers to a person with a mind "so weak or unbalanced at the time of the execution of the deed that he would not understand and comprehend the purport and effect of what he was then doing."⁷⁴³ Another case refers to the capacity "of understanding and appreciating the extent and effect of business transactions in which he engaged."⁷⁴⁴ In *In re Nelson's Estate*,⁷⁴⁵ an eighty-eight year old woman was found competent to convey her property on the basis that she had managed her finances, signed various cheques and taken care of her affairs in the past. The medical evidence of incompetence was found of limited relevance, as it referred to her ability to take care of herself, rather than her estate. The court devoted little discussion to the issues discussed in the *Buuck* test, as she had in fact been conducting her own affairs.

The case law is not consistent as to whether the standard of competence in testamentary matters is the same as in contractual matters. There is authority that the standard of competency is the same for wills as for contracts.⁷⁴⁶ Other authority holds that a lower standard of competence is required for a will than for

⁷⁴⁰ *Fleming* at 383.

⁷⁴¹ *Ibid* at 381. A similar formulation is found in *Elwood v. O'Brien*, 74 N.W. 740 (Iowa, 1898) and *Tate v. Murphy*, 217 P. 2d 177 (Okl., 1949).

⁷⁴² *Buuck v. Kruckeberg*, 95 N.E. 2d 304 (Indiana, 1950) at 306.

⁷⁴³ *Blochowitz v. Blochowitz*, 240 N.W. 586 (Neb., 1932) at 590.

⁷⁴⁴ *Hanks v. McNeil Coal Corporation*, 168 P. 2d 256 (Colo., 1956) at 560.

⁷⁴⁵ 185 S.W. 2d 890 (Missouri, 1945). See also *Tate v. Murphy*, 217 P. 177 (Okl., 1949) for a similar situation.

⁷⁴⁶ *Hall v. Unger*, 4 Sawyer 672 at 679 (Cal., 1867); *Hanks v. McNeil Coal Corporation*, 168 P. 2d 256 (Colo., 1946).

a contract.⁷⁴⁷ Either way, the tests for testamentary competency are phrased in a remarkably similar fashion to those for contractual competency. The standard test of testamentary capacity, is that the testator must be of "sound and disposing mind", usually understood as having the ability to retain in his memory, without prompting, the extent and condition of his property and to comprehend how it is to be disposed of, and to whom, and upon what consideration.⁷⁴⁸

The tests as stated do not on their face appear to impart a lower threshold of competence under American law than under English or Canadian law. The articulation of the standard is misleading in this regard. An informal perusal of the case law would suggest that it is, and has historically been, very difficult to strike out a will or contract on the basis of lack of competence, as distinct from undue influence.

The theory of the American doctrine of undue influence is relatively clear. Essentially, the court will protect persons of doubtful competence from being taken advantage of, by refusing to give legal effect to contracts or wills executed by such persons, if they are unfair and the result of undue influence. The language of the cases as to the type of influence at issue is sometimes relatively broad, such as "an unlawful or fraudulent influence which controls the will of the grantor."⁷⁴⁹ A somewhat fuller discussion is contained in the 1921 case of *Pass v. Stephens*:

It is important to understand what constitutes undue influence as will vitiate a deed procured by its exercise over the grantor. Undue influence which will justify the setting aside of an executed deed must have been of such a nature as to deprive the grantor of his free agency, and thus to render his act more the offspring of the will of another than of his own will. It is not sufficient to avoid a deed that its execution was procured by honest argument or persuasion unattended with fraud.⁷⁵⁰

The court then indicates that the influence must be wrongful in a legal sense, a species of fraud.⁷⁵¹ Consistent with this comment, there is case law to the effect that "the affection, confidence, and gratitude of a parent to a child which inspires

⁷⁴⁷ See *Stevens v. Vanclève*, 4 Wash. 262 (N.J., 1822); *In Re Good's Estate*, 274 S.W. 2d 900 (Tenn., 1955).

⁷⁴⁸ See *In Re Alexieff's Will*, 94 N.Y.S. 2d 32 (1949); *Ehrst v. Broodhyer*, 244 S.W. 2d 625 (Ark., 1951) at 627; *Dyde v. Rudy*, 25 A. 2d 457 (Maryland, 1942) at 459; *In the Matter of the Estate of Brown*, 753 P. 2d 1028 (Wyo., 1988) at 1031. The case law indicates only minor alteration since *Stevens v. Vanclève*, 4 Wash. 262 (N.J., 1822) and *Harrison v. Rowan*, 3 Wash. 500 (N.J., 1820), both quoted above.

⁷⁴⁹ *Blockswitz v. Blockswitz*, 240 N.W. 586 (Neb., 1952), at 591.

⁷⁵⁰ *Pass v. Stephens*, 190 P. 712 (Ariz., 1921) at 716. References omitted.

⁷⁵¹ *Ibid.*

the gift is a natural and lawful influence, and will not render it voidable unless this influence has been so used as to confuse the judgment of the donor.⁷⁵²

The issue is actual undue influence. Demonstration of the motive and the opportunity for the exercise of undue influence is not sufficient, absent proof of actual interference.⁷⁵³ The wishes of the allegedly influenced party are not necessarily determinative of whether such influence has been executed, as explained in the following passage from *Doyle v. Rody*:

Unsoundness of mind, when not reaching to mania or idiocy, is incompatible with the semblance of perfect reason on occasion or for a period; and, where undue influence has been craftily plied, it so insidiously possess the mind of its victim with false impressions or delusions, that he often voluntarily, and even eagerly, performs the act, into which he has been skilfully duped. The law is jealous to defeat a fraudulent use of the means afforded by intimacy of association. And it is not inconsistent with the exercise of undue influence or artifice, that the instrument assailed was executed voluntarily, and with a knowledge of its contents.⁷⁵⁴

The result is that the court has exercised tremendous discretion in the application of the undue influence doctrine. There is old authority that extreme weakness, even if short of legal incapacity, would "raise an almost necessary presumption of imposition."⁷⁵⁵ Similarly, the failure to receive independent advice prior to the execution of a contract has been held to be a factor for a court's consideration.⁷⁵⁶

Some courts have held that the terms of the contract are a factor in determining whether there has been undue influence. *Allore v. Jewell* states that the consideration must be "grossly inadequate" before a court will intervene.⁷⁵⁷ The consideration was also a factor for the court to take into account in *Hanks v. McNeil Coal Corporation*:

Inadequacy of consideration is evidence from which fraud may be inferred. Such evidence may be weak or strong. Inadequacy so gross as to shock the conscience is such convincing evidence of fraud as to shift the burden of the evidence upon the party seeking to enforce the contract. Relief is given in

⁷⁵² *Blochowitz v. Blochowitz*, 240 N.W. 586 (Neb., 1932) at 590, citing various earlier authorities. Cf. *Daughton v. Parson*, 423 N.W. 2d 894 (Iowa, 1988), *contra*.

⁷⁵³ *Williams v. Church*, 198 P. 2d 995 (Okla.); *Arnau v. Cochran*, 361 S.E. 2d 173, (Ga., 1987).

⁷⁵⁴ *Doyle v. Rody*, 25 A. 2d 457 (Maryland, 1942) at 461 f., quoting *Cherbonnier v. Evitts*, 56 Md. 276.

⁷⁵⁵ *Harding v. Wheaton*, 2 Mason, *affd. sub nom Harding v. Handy*, 11 Wheat. 125 (S.Ct.), quoted in *Allore v. Jewell*, 94 U.S. 506 (1876) at 511.

⁷⁵⁶ See *Allore v. Jewell*, 94 U.S. 506 (1876) at 512.

⁷⁵⁷ At 511.

equity, however, not on the ground of the inadequacy, but on the ground of the fraud as evidenced thereby.⁷⁵⁸

The courts which discuss the consideration paid under the contract are quick to affirm that it is relevant only as evidence of fraud or undue influence, and that the court will not set aside a transaction between freely contracting parties merely because it is improvident.⁷⁵⁹

It is reasonably clear that undue influence will be presumed if the beneficiary under the will or the other party to the contract is in a fiduciary relationship to the party of marginal competence. This would appear to be a relatively elastic set of relationships. One nineteenth century court even extended the fiduciary relationship to include the relationship between spiritualist and medium:

There is much evidence tending to show undue influence. It is established that the relation between the parties was confidential, in consequence of her claim to power as a medium, through which she had great control over him [the grantor]. This being established, the burden was cast upon her of showing that there was no undue influence. The rule applies with peculiar force to the relation of one and his priest, confessor, clergyman, or spiritual adviser, and certainly with no less force to the relation between one who is a firm believer in, not to say a monomaniac upon, the subject of spiritualism, and the medium in whom he has confidence, and upon whom he habitually relies. The cases upon the subject are numerous, but the law, so far as necessary here, is crystallized in the Civil Code. Section 2219 provides that every one who voluntarily assumes a relation of personal confidence with another is a trustee, and section 2235 raises the presumption that all transactions between such persons, by which the person trusted obtains an advantage, are entered into under undue influence.

We think that this is sufficient to show that there was evidence upon which the court could find the existence of a relation of a peculiar trust and confidence between them, similar to that between a religious devotee and his spiritual adviser and the proof of which would throw upon the plaintiff the burden of showing fair dealing.⁷⁶⁰

The cases would suggest that the abuse of a position of trust can thus be seen as the paradigm of a relationship importing undue influence.

The evidence introduced on trials of competency largely reflects the tests to be proven. Thus regarding competency proper, there has often been testimony

⁷⁵⁸ *Hanks v. McNeil Coal Corporation*, 168 P. 256 (Colo., 1946), at 261.

⁷⁵⁹ *Hanks v. McNeil Coal Corporation*, 168 P. 256 (Colo., 1946), at 261 f.; *Kilgore v. Cross and Diver* 1 McCrary 144 (Ark., 1880), *Allore v. Jewell*, 94 U.S. 506 (Mich., 1876).

⁷⁶⁰ *Connor v. Stanley*, 14 P. 306 (Cal., 1887) at 307 f.

from acquaintances of the allegedly incompetent person, offering evidence as to the rationality, behaviour, and level of understanding of the subject. Regarding undue influence, there will often be witnesses as to the relationship between the parties.

There are a few significant differences from English case law as to the evidence which might be brought. There was American authority in the nineteenth century that prior wills and statements of the testator when competent were not relevant to a determination of testamentary competency.⁷⁶¹ Such considerations were considered to be irrelevant, as it was the intention of the testator at the time of execution of the will at issue that constitutes the court's central concern. Prior statements were also considered to be hearsay, and otherwise unreliable. These rules have now changed. General conduct of the subject, including statements made by the subject are now admissible,⁷⁶² as are previous wills.⁷⁶³

It is arguable that the medical perspective has played a more significant role in the development of the standards of competence in the American case law than in the English. This is in part because the American case law continued developing into the twentieth century, when the medical profession was becoming more organized, more knowledgeable and more prestigious. The influence pre-dates this century, however.

The influence of the medical professionals may result in part from an 1838 work by Isaac Ray, *The Medical Jurisprudence of Insanity*. Ray was a physician, and eventually a founder of the American Psychiatric Association. This work was not uncommonly quoted in the decisions of the nineteenth century, perhaps in part as it may have organized the issues more effectively than existing treatises of lawyers. In any event, the American courts tended to take cognizance of the medical perspective to a much greater degree than their English counterparts. In the 1867 case of *Hall v. Unger*, for example, the California Circuit Court expounds the current medical line on the nature of insanity, providing synopses of idiocy, monomania, dementia, and mania.⁷⁶⁴ While the court finds that these diagnoses are not determinative of the issue of mental competency, an attempt is made to discuss the relationship between the various conditions and the legal definitions, to ensure

⁷⁶¹ *Turner v. Hand*, 3 Wallace Jr. 88 (Penn., 1855); *Stevens v. Vancleve*, 4 Wash. 262 (N.J., 1822).

⁷⁶² See *American Jurisprudence*, (2nd ed.), (Rochester: Lawyers Co-Operative, 1968), Vol. 41 at para. 134.

⁷⁶³ See *Dillman v. McDanel*, 78 N.E. 590 (Ill., 1906); *Blochowitz v. Blochowitz*, 240 N.W. 586 (Neb., 1932); and *Newton v. Carberry*, 5 Cranch 626 (Wash., 1840).

⁷⁶⁴ *Hall v. Unger*, 4 Sawyer 672 (Cal., 1867) at 676 ff.

that the law took account of the medical reality. Compare this to the English case of *Waring v. Waring*,⁷⁶⁵ where the court, notwithstanding the medical evidence, effectively denied that monomania existed, or that it had any relevance to the legal understanding of competence.

A concrete difference between the English and American views of medical fact arise as to the issue of whether insanity of family members was admissible in evidence. In England, the insanity of a family member was not admissible as evidence of the insanity of other family members in civil actions.⁷⁶⁶ There is rare American authority for the proposition that such evidence was admissible even without a proof that the type of insanity at issue would be hereditary,⁷⁶⁷ itself perhaps an indicator of the prevalence of the disease-based or medical conception of insanity. Usually, however, the rule was that evidence of insanity of a family member would be admissible if and only if evidence was tendered that the type of insanity at issue was such "as would taint the blood" of the family.⁷⁶⁸ The admissibility of the evidence was thus largely a matter of medical fact.

The evidence accorded to physician witnesses was similarly accorded higher regard in American case law. As early as 1820, their expertise in the nature of insanity was accorded respect:

As to the subject-matter of the testimony, it may be well to remark that the mere opinions of the witnesses are entitled to little or no regard, unless they are supported by good reasons founded on facts which warrant them in the opinion of the jury. If the reasons are frivolous or inconclusive, the opinions of the witnesses are worth nothing.

To this, as a general rule, the opinions of medical men, even although they did not see the testator, may be considered as an exception. A physician may, with some degree of accuracy, form an opinion of the nature of the disorder and its probable effect upon the mind where the symptoms are truly stated to him; because, from a long course of experience and observation by himself and others of the profession, such have been the ordinary effects of these symptoms. But, to entitle such opinions to the regard of a jury, they should be satisfied by the other evidence in the cause that the symptoms did exist in the particular case under consideration.⁷⁶⁹

⁷⁶⁵ (1848), 6 Moore 341.

⁷⁶⁶ See *M'Adam v. Walker and Another* (1813) 1 Dow. 148; *Doe d. Mather v. Whitefoot and Williams* (1838) 8 C & P. 270.

⁷⁶⁷ See, for example, *Prentiss v. Bates*, 53 N.W. 153 (Mich., 1892), at 155.

⁷⁶⁸ See *In Re Myer's Will*, 76 N.E. 920 (N.Y., 1906) (evidence not admitted, as proof of hereditary nature of disease not made); *Reichenbach v. Ruddach*, 18 A. 432 (Penn., 1889) (again, evidence not admitted as proof of hereditary nature not made).

⁷⁶⁹ *Harrison v. Rowan*, 3 Wash. 580 (N.J., 1820).

The actual decision as to competence (absent statutory direction) always remained in the purview of the judge or jury. Nonetheless, it is difficult to imagine an English court according the testimony of a physician such high respect.

As we have seen, the American courts did not centre their understanding of competence on delusions. On this topic, the view of American law is very similar to English law in the post-*Goodfellow* era. The definition of delusion generally adopted into the American jurisprudence was "belief that something exists which does not exist, and which no rational person, in the absence of evidence, would have believed to exist".⁷⁷⁰ This definition is essentially similar to the definition established in the English jurisprudence, in cases such as *Dew v. Clark and Clark*⁷⁷¹ and *Prinsep and The East India Co. v. Dyce Sombre and Others*.⁷⁷² Curiously, given this definition, there is authority for the proposition that the existence of a delusion is a matter of law, not of fact, and is therefore to be decided by the judge and not the jury.⁷⁷³

Certainly by the turn of the century, the rule in American courts was that a causal connection had to be demonstrated between the delusion and the executed document in order to invalidate the document.⁷⁷⁴ In the event that this was not demonstrable, some courts took cognizance of delusions in other ways. Thus, for example, in *Reichenbach v. Ruddach*, an undue influence case, delusions were considered as evidence of the degree to which the testator had been affected by the cause of his disorder, in this case "a life of gross intemperance, profligacy, and sensuality."⁷⁷⁵ The belief in spiritualism which bordered on monomania in *Conner*

⁷⁷⁰ See *In Re Hemingway's Estate*, 45 A. 726 (Penn., 1900) at 727. Similar definitions are found in *Re Good's Estate*, 274 S.W. 900 (Tex., 1955), and *Appeal of Kimberly*, 36 A. 847 (Conn., 1896) at 849.

⁷⁷¹ (1828), 3 Add. 79.

⁷⁷² (1856), 10 Moore 232, esp. at 246.

⁷⁷³ *Appeal of Kimberly*, 36 A. 847 (Conn., 1896) at 849. A similar result would not obtain in Canada or England, where it has been decided that whether something is a delusion is a matter of fact, to be decided by the jury: *Robertson v. Kelly* (1883), 2 O.R. 163 (Q.B.D.), citing *Jenkins v. Morris*, *supra*.

⁷⁷⁴ *In Re Hemingway's Estate*, 45 A. 726 (Penn., 1900) at 727; *Eubanks v. Eubanks*, 195 N.E. 521 (Ill., 1935); *Doyle v. Rody*, 25 A. 2d 457 (Maryland, 1942); *Roller v. Kartz*, 129 N.E. 2d 693 (Ill., 1955). The point is not entirely clear, but the causal connection would apparently not have been required by the court in *Appeal of Kimberly*, 36 A. 847 (Conn., 1896).

⁷⁷⁵ *Reichenbach v. Ruddach*, 18 A. 432 (Penn., 1889), at 437.

v. *Stanley* was discussed not in the context of a delusion, but as a catalyst for the creation of a fiduciary relationship between the grantor and the medium.⁷⁷⁶

The American opinions as to what constitutes delusions raise a few issues not discussed in the English decisions. Some of these may be a reflection of the period. Thus, for example, a belief that one's daughter was a witch did not constitute a delusion in 1887.⁷⁷⁷ Perhaps more substantial is the decision in *Newton v. Carberry*, where it was held that the court was without jurisdiction to determine whether a doctrine held by a religious sect was true or false, and therefore whether members of that sect would be *ex hypothesi* delusional.⁷⁷⁸

The American jurisprudence adopts two sorts of tests in matters relating to incompetency. The test of capacity *per se* is a functional test, with a very low standard. The test of undue influence is a test which looks to both the functional abilities of the allegedly marginally competent individual and the power dynamic between parties, in an attempt to protect the weaker party. Like the English courts, the American courts purport to be unconcerned with the "appropriateness" of the dispositions under the will or the actual terms of the contract, except insofar as it was evidence of fraud. Unlike the English courts, at least in the reported cases, this is not mere posturing and there are few tales of the injustice of disinheriting children. Cases are not particularly rare where the losing party is the party to whom "natural bonds of affection" would normally be owed. The English comment that "a rational act, rationally performed, is the strongest proof of a lucid interval" simply does not appear in the American case law.⁷⁷⁹ It is perhaps an open

⁷⁷⁶ *Conner v. Stanley*, 14 P. 306 (Cal., 1887).

⁷⁷⁷ See *Schildnecht v. Rompf's Executor*, 4 S.W. 235 (Ky., 1887).

⁷⁷⁸ *Newton v. Carberry*, 5 Cranch 626 (Washington, 1840). A similar decision could be expected from a Canadian court, particularly in light of the guaranteed freedom of religion in section 2 of the *Charter of Rights and Freedoms*.

⁷⁷⁹ The one significant exception from the cases surveyed is *Dillman v. McDanel*, 78 N.E. 590 (Ill., 1906), at 596:

Instructions numbered 5 and 18 for appellees advised the jury that they might take into consideration, in determining the question of mental capacity, any inequality of distribution or unreasonableness of the provisions of the will, and the reasonableness of the will with reference to the amount of the testator's property and the situation and condition, financially, of his relatives. ... We have held that in cases of this character, "intrinsic evidence of the will itself, arising from the unreasonableness or injustice of its provisions, taking into view the state of the testator's property, family, and the claims of particular individuals, is competent and proper for the consideration of the jury." [citation omitted].

question as to how representative the reported decisions are. Consider the following passage from a nineteenth century case:

In contests concerning wills, where the testator has made, or has seemingly made, an unequal or inequitable disposition of his property among those occupying the same relation to him by consanguinity or otherwise, there is a disposition in most minds to seek for a cause for holding the will invalid. The inclination in this direction that is found to exist in the minds of most, if not all, jurors, cannot always be controlled by instructing them there is no law requiring a testator, nor is he bound, to devise his property equitably or in equal proportions among his heirs. Of course, the law is he may make such dispositions of his property as he sees fit, and he may bestow his bounty where he wishes, either upon his heirs or others. While this is undoubtedly the law, the common mind is disinclined to recognize it, and jurors will too frequently seize upon any pretext for finding a verdict in accordance with what they regard as natural justice.⁷⁶⁰

The desire for juries and judges to see justice done is probably an eternal truth. While the American case law is much more discrete than the English in this regard, it would be naive to pretend that findings of incompetence and undue influence did not follow expedience to some degree.

Guardianship, Conservatorship and Consent to Treatment

In the realm of general guardianship and conservatorship, the state courts inherited the existing English law at the time of the revolution. Absent statutory direction to the contrary, for example, the proceedings employed by the court were by writ of *de lunatico inquirendo* as in Britain.⁷⁶¹

Unlike the law regarding testamentary and contractual capacity, however, a dual standard of incompetence, depending on the presence or absence of undue influence, has not been developed. This presumably reflects the fact that a general determination of incompetence is prospective. An inquisition into general competence cannot refer to a specific document in an evaluation of whether undue influence was a significant factor in its execution.

The resulting standard thus does not refer to undue influence. It is not the minimal test of mental incompetency which would be used to render a contract void *ab initio*. Instead, the test tends to refer to the individual's ability to survive in everyday life. Thus in the case of *Lewis v. Lewis*, the test is "such a degree of mental incapacity as to connote inability to understand and deal with the common

⁷⁶⁰ *Freeman v. Easley*, 7 N.E. 656 (Ill., 1886) at 658.

⁷⁶¹ *v. Burke v. Wheaton* Wash. 340 (1828).

affairs of life."⁷⁸² The standard developed is more similar to the English standard in its application, in that extreme incompetence need not be shown to justify an order for guardianship. Further, although a standard which required the ward to make "responsible decisions" has been ruled unconstitutional,⁷⁸³ the breadth and generality of the test articulated may allow for at least some consideration of the results of the choices made in the determination of general competency.

By the middle years of this century, most states had enacted statutes which associated incompetence with institutionalization. Further, many of the leading American decisions regarding guardianship of the person occurred in the context of medical treatment. In order to understand competency in this context, it is necessary to consider the general history of law and medicine in the United States over the last few decades.

Prior to the 1960s, there would appear to have been a general perception that the law had a limited role in the medical system. While the law had always required consent to treatment, it was not until the late 1950s that the courts began to develop firm standards as to what information a patient needed prior to a consent being valid.⁷⁸⁴ Since that time, the law has entered the medical realm in several distinct ways.

Firstly and most pervasively, the American law has developed a doctrine of informed consent. For a consent to be valid, it must be voluntary, knowing, and competent.⁷⁸⁵ Most frequently, informed consent cases concern the extent of the information provided to a patient regarding a proposed treatment. In early American cases, the information to be disclosed was determined according to the standards of the medical profession.⁷⁸⁶ More recently, and consistent with the move away from strict medical models of decision making, the standard of information to be provided is that which the average, reasonable or prudent patient would want to hear.⁷⁸⁷

⁷⁸² *Lewis v. Lewis*, 20 S.E. 2d 107 (S.C., 1942) at 109.

⁷⁸³ *In Re Boyer*, 636 P. 2d 1085 (Utah, 1981).

⁷⁸⁴ The law of informed consent in the United States is generally understood to start with the case of *Salgo v. Leland Stanford Jr. University Board of Trustees*, 317 P. 2d 170 (Cal., 1957).

⁷⁸⁵ See *Kaimowitz v. Department of Mental Health*, 1 M.D.L.R. 147 (Mich., 1973) and numerous other decisions.

⁷⁸⁶ See, for example, *Natanson v. Kline*, 350 P. 2d 1093 (Kan., 1960).

⁷⁸⁷ See, for example, *Canterbury v. Spence*, 464 F. 2d 772 (D.C., 1972); and *Largey v. Rothman*, 540 A. 2d 504

Secondly, the civil rights movement eventually caught up with persons with developmental handicaps and psychiatric difficulties. Initially, in cases such as *Wyatt v. Stickney*,⁷⁸⁸ the issue was ensuring an adequate standard of treatment in psychiatric facilities. In those cases, the Alabama court established, with considerable detail, standards of accommodation, care and treatment which were constitutionally required for persons committed to psychiatric facilities. *Lessard v. Schmidt*⁷⁸⁹ in 1972 affirmed the constitutional right of any patient upon civil committal to an adversarial-style hearing with due process safeguards. *O'Connor v. Donaldson*⁷⁹⁰ in 1975 held that the civil committal of an individual who was not dangerous and was capable of living safely in the community either by himself or with available supports was a violation of the constitutional right to liberty.

More directly relevant for our purposes, the courts also began to separate institutionalization from competence. Thus committed patients were held by the court not to be *per se* incompetent to consent to treatment.⁷⁹¹ Medication without the consent of the patient has been held to be a violation of the patient's right to privacy, a quasi-constitutional right, or liberty, a right actually contained in the constitution.⁷⁹² Consistent with these decisions, state legislatures over the last twenty years have enacted statutes which have separated competency from institutionalization. As of 1985, forty-two states specifically provided that competency was not affected by institutionalization.⁷⁹³

(N.J., 1968).

⁷⁸⁸ *Wyatt v. Stickney*, 325 F. Supp. 781 (Ala., 1971), var. 344 F. Supp. 373 (Ala., 1972). See further *Mariarella v. Kelley*, 349 F. Supp. 575 (N.Y., 1972), where a similar set of arguments was successful in facilities for children.

⁷⁸⁹ *Lessard v. Schmidt*, 349 F. Supp. 1078, (Wisc., 1972).

⁷⁹⁰ *O'Connor v. Donaldson*, 422 U.S. 563 (Fla., 1974).

⁷⁹¹ See, for example, *Rennie v. Klein*, 462 F. Supp. 1131, (N.J., 1978); mod. 476 F. Supp. 1294 (1979); mod. & rem. 653 F. 2d 836 (1981); *Goedecke v. State, Dep't of Inst.*, 603 P. 2d 123 (1979); *Rogers v. Okin*, 634 F. 2d 650 (1980), vac. and rem. 102 S. Ct. 2442 (1982), 458 N.E. 2d 308 (Mass., 1983); *Opinion of the Justices*, 465 A. 2d. 484 (N.H., 1983); *Savastano v. Saribeyoglu*, 480 N.Y.S. 977 (1984).

⁷⁹² *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d 417, (Mass., 1977); *In Re Boyd*, 403 A. 2d. 744 (D.C., 1979); *Lojuk v. Quandt*, 706 F. 2d 1456 (Ill., 1983) affirmed on other grounds, 770 F. 2d 619; cert denied, 474 U.S. 1067 (1986); *Savastano v. Saribeyoglu*, 480 N.Y.S. 977 (1984).

⁷⁹³ See J. Parry, "Incompetency, Guardianship, and Restoration", Chapter seven of *The Mentally Disabled and the Law*, (3rd ed.), S.J. Brakel, J. Parry and B. Weiner (eds.), (Chicago: American Bar Foundation, 1985) at 375.

There is strong authority for the proposition that prior to any forced medication of a patient, a judicial hearing must be held to determine that patient's competence.⁷⁹⁴ This line of authorities was called into doubt with the decision of the United States Supreme Court in *Youngberg v. Romeo*.⁷⁹⁵ While strictly a case involving minimal standards for psychiatric facilities, the court made the following remarks about judicial involvement in the field of mental health:

In determining what is "reasonable" -- in this and in any case presenting a claim for training by a State - we emphasize that courts must show deference to the judgment exercised by a qualified professional. By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there is certainly no reason to think judges or juries are better qualified than appropriate professions in making such decisions. (Courts should not "second guess the expert administrators on matters on which they are better informed"). For these reasons, the decision, if made by a professional, is presumptively valid; liability may be imposed only when the decision by the professional is such a substantial departure from the accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.⁷⁹⁶

This decision has been used to justify decisions of incompetence made by medical professionals rather than the courts. In *U.S. v. Leatherman*, for example, a person who had been found not guilty by reason of insanity was held to have been appropriately treated on the basis of a finding by hospital staff that he was incompetent to consent, and upon the wishes of his family, notwithstanding that there was no formal appeal mechanism for the hospital's finding.⁷⁹⁷

Another interpretation of the *Youngberg* decision suggested that the appropriate due process hearing does not necessarily need to be held by a court. This interpretation would be consistent with the decision in *U.S. v. Charters*, where the concern of the court was that treatment decisions were to be made by independent arbiters rather than by the staff of the medical facility.⁷⁹⁸ Other courts have implicitly argued that these comments from *Youngberg* do not apply to

⁷⁹⁴ *In the Matter of Schiller*, 372 A. 2d 360 (N.J., 1977); *Bentley v. State ex rel. Rogers*, 398 So. 2d 992 (Fla., 1981) (decided based on the right of privacy contained in the Florida state constitution); *People v. Medina*, 705 P. 2d 961 (Colo., 1985); *Jarvis v. Levine*, 418 N.W. 2d 139 (Minn., 1988), and *Riese v. St. Mary's Hospital and Medical Center*, 243 Cal. Rptr. 241 (1987).

⁷⁹⁵ *Youngberg v. Romeo*, 102 S. Ct. 2452 (Penn., 1982).

⁷⁹⁶ *Ibid* at 2461 f. References omitted. Parentheses and quotation marks in original.

⁷⁹⁷ *U.S. v. Leatherman*, 580 F. Supp. 977 (D.C., 1983).

⁷⁹⁸ *U.S. v. Charters*, 829 F. 2d 479, (Virg., 1987).

competency. The California Court of Appeal has distinguished the competency question in this way:

The *Act* [referred to as *LPS*] accepts the proposition that, as stated by the highest court of New York, mental illness "often strikes only limited areas of functioning, leaving other areas unimpaired, and consequently ... many mentally ill persons retain the capacity to function in a competent manner." Consequently, the task for the court is simply to determine whether a patient refusing medication is competent to do so despite his or her mental illness. The determination of this capacity "is uniquely a judicial, not a medical function." As stated by an eminent psychiatrist, "Competence is not a clinical, medical, or psychiatric concept. It does not derive from our understanding of health, sickness, treatment, or persons as patients. Rather, it relates to the world of law, to society's interest in deciding whether an individual should have certain rights (and obligations) relating to person, property and relationships". Though judicial determinations of competency to give informed consent to proposed treatment are not easy, they are no more difficult than other types of competency assessments required to be made by trial courts under *LPS* and in other connections. The task is facilitated by the increasing ability of mental health professionals to effectively assist in the forensic enterprise.⁷⁹⁹

Absent a further directive from the United States Supreme Court, it is not clear whether the determination of competence may be made by a medical professional directly, or whether it must be made by a court or independent administrative tribunal.⁸⁰⁰

Furthermore, it is not clear what the ramifications of a finding of incompetence are. A guardian will normally be appointed. In which case, consent of the guardian must be obtained prior to the performance of medical procedures, even if the incompetent patient consents to the operation.⁸⁰¹ In general, it would appear that absent a judicial order, the guardian is to decide on the basis of what the patient would have decided, if competent.⁸⁰² The guardian is therefore to take into serious consideration any wishes expressed by the patient when he or she was competent.⁸⁰³ Some courts have held that some medical procedures are so intrusive that they should never be administered, merely upon the consent of the

⁷⁹⁹ *Riese v. St. Mary's Hospital and Medical Center*, 243 Cal. Rptr. 241 (1987). Quotation marks and parentheses in original; references and footnotes omitted.

⁸⁰⁰ American case law in most situations allows emergency treatment of incompetent persons or persons whose competence is in doubt without the consent of the patient, so the time pressure for a decision is not a controlling factor as to who is to make the decision.

⁸⁰¹ *Aponie v. U.S.*, 582 F. Supp. 65 (Puerto Rico, 1984).

⁸⁰² *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E. 2d 417, (Mass., 1977); *In Re Boyd*, 403 A. 2d 744 (D.C., 1979); *In Re Roe*, 421 N.E. 2d 40 (Mass., 1981); *Delio v. Westchester County Medical Center*, 516 N.Y.S. 2d 677 (1986).

⁸⁰³ See, for example, *In Re Roe*, 421 N.E. 2d 40 (Mass., 1981); *Delio v. Westchester County Medical Center*, 516 N.Y.S. 2d 677 (1986).

guardian.⁸⁰⁴ In any event, it appears that a court application for treatment, pursuant to the court's *parens patriae* power, is always available.

A complicating factor in assessing such treatment applications is that a determination of the patient's competence does not generally determine whether or not treatment will be given. There have been cases which affirm the absolute right of a competent patient to refuse treatment outside an emergency context,⁸⁰⁵ and there are many cases which affirm that the state interest in overriding a competent refusal of treatment must involve very serious factors indeed. The stronger precedents, however, hold that in some circumstances the refusal of a competent patient may be overridden. To further complicate matters, the inverse is also true: an incompetent patient who refuses treatment is considered to have a liberty interest which requires respect, although the state interests in overriding an incompetent refusal of treatment are presumably not nearly as high.⁸⁰⁶

In the tension between the patient's right to refuse treatment and the state's *parens patriae* power, competence in the United States is often only one of the factors which comes into play. The *Roe* case provides an indication of the breadth of factors some courts may consider in deciding whether treatment ought to be given to a refusing patient. In it, the court identified the following parameters:

- a. the intrusiveness of the proposed procedure;
- b. the possibility of adverse side effects;
- c. whether or not treatment is needed to control an emergency situation;
- d. the ward's expressed preference, whether or not the ward is competent;
- e. the ward's religious belief;
- f. the impact on the family of the ward, if treatment is or is not given;
- g. the consequences if treatment is refused; and
- h. the prognosis with treatment.⁸⁰⁷

As these criteria would indicate, such cases are likely to be decided largely on their facts. A few general comments may be made, however.

⁸⁰⁴ These have usually been cases regarding administration of psychiatric treatment and the withdrawal of life-supporting treatment: see further below.

⁸⁰⁵ See, for example, *Davis v. Hubbard*, 506 F. Supp. 915 (Ohio, 1980); *In Re K.K.B.*, 609 P. 2d 747 (Okla., 1980); *Rogers v. Orkin*, 478 F. Supp. 1342 (Mass., 1979) (but compare with appeal decision reported at 634 F. 2d 650 (1980), which was more restrictive in its approach).

⁸⁰⁶ See, for example, *In Re Boyd*, 403 A. 2d 744 (D.C., 1979); *In Re Roe*, 421 N.E. 2d 40 (Mass., 1981).

⁸⁰⁷ *In Re Roe*, 421 N.E. 2d 40 (Mass., 1981).

The disputes arise when an individual or their substitute refuses treatment, and the issue is normally, therefore, whether a right to refuse treatment should prevail. The cases have fallen into three primary categories: refusal of life-sustaining treatment by aged or terminally ill individuals; refusals of psychiatric treatments; and refusals based on religious objections to treatments.

Since the precedent-making case of *In the Matter of Quinlan*⁸⁰⁸ in 1976, the courts have generally, with appropriate care, been prepared to allow the refusal of life-supporting treatment by the very old or the terminally ill, particularly where the treatment was extreme or intrusive. The primary concern of the courts appears to be that the patient has made a knowing decision. Thus in *In re Application of Lydia E. Hall Hospital*,⁸⁰⁹ the court upheld the refusal of kidney dialysis by an elderly patient, as the patient apparently understood that the refusal of the treatment would put her life and health in peril. In *In the Matter of Quackenbush*⁸¹⁰, an elderly gentleman was permitted to refuse amputation of his legs, which had become infected with gangrene. The patient was suffering from organic brain syndrome, but continued to have lucid moments. During these moments, he did not hallucinate, was reasonably alert and responded well to questions. He appeared to have a reasonable understanding of his condition, and was therefore adjudged competent and permitted to refuse the amputations. Recently, a New Jersey court explained that their concern in these cases was that "a patient who has decided to forgo life-sustaining treatment is competent; is informed about his or her prognosis, the medical alternatives available, and the risk involved; and has not been coerced."⁸¹¹ In that case, the court attempted to lay out a procedure to be followed, to keep the matter out of the courts and in the private realm. The case law further supports the proposition that a guardian may apply to the court for a discontinuation of life-sustaining treatment, and such a request will be granted if it would have been the wish of the patient. This does not extend to children, however, and there is authority for the proposition that parents may not refuse life-sustaining treatment for children.⁸¹²

⁸⁰⁸ *In the Matter of Quinlan* 355 A. 2d 647; cert denied sub nom *Garger v. New Jersey*, 429 U.S. 922, 97 S. Ct. 319.

⁸⁰⁹ *In re Application of Lydia E. Hall Hospital*, 455 N.Y.S. 2d 706 (1982).

⁸¹⁰ *In the Matter of Quackenbush*, 383 A. 2d 785 (N.J., 1978).

⁸¹¹ *In the Matter of Farrell*, 529 A. 2d 404 (N.J., 1987) at 414.

⁸¹² *Eichner v. Dillon*, 423 N.Y.S. 2d 580; modified 426 N.Y.S. 2d 517 (1980); modified 438 N.Y.S. 2d 266; cert denied sub nom. *In Re Storar*, 454 U.S. 858 (1981). This is also in general good law in Canada: see *Superintendent of Family and Child Service v. R.D. and S.D.* (1983), 42 B.C.L.R. 173 (B.C.S.C.) regarding

Psychiatric medications have been the subject of a significant amount of litigation, much of it contradictory. Thus, for example, in the *Roe* case, psychiatric treatments were held to be sufficiently intrusive so that a guardian could not consent to them without court approval, while other cases affirm the right of the guardian to consent.⁸¹³ The trend of cases appears to be that the courts recognize that psychiatric treatment tends to be extremely intrusive. There is authority giving competent patients a firm right to refuse such drugs in non-emergency situations.⁸¹⁴ In addition, the fact that these drugs impair the ability to form ideas has been held to be a potential violation of freedom of speech in the first amendment to the American constitution.⁸¹⁵ There is authority for the proposition that forced medication of prisoners which are painful or threatening, including psychotropic medication, could constitute cruel and unusual punishment under the constitution.⁸¹⁶ All of this suggests that the courts will act with particular care when psychiatric treatment is at issue.

Finally, a number of cases have considered the rights of patients who refuse treatment for religious reasons. A precedent from the 1960s would suggest that a refusal of an adult patient to consent to treatment on religious grounds might nonetheless be overridden by the courts, on the basis of the *parens patriae* interest of the state.⁸¹⁷ More recent authority suggests that such an objection will not normally be overridden by the courts.⁸¹⁸ The concern of the courts in these cases

children and *Re Eve* (1986), 13 C.P.C. (2d) 6 (S.C.C.) regarding persons found to be mentally incompetent. These cases were discussed previously in the section regarding children.

⁸¹³ *U.S. v. Leutherman*, 580 F. Supp. 977 (D.C., 1983).

⁸¹⁴ See, for example, *Savastano v. Sariheyoglu*, 480 N.Y.S. 977 (1984); *Bee v. Greaves*, 744 F. 2d 1387 (Utah, 1984); *U.S. v. Charters*, 829 F. 2d 479, (Virg., 1987); *Jarvis v. Levine*, 418 N.W. 2d 139 (Minn., 1988).

⁸¹⁵ *Bee v. Greaves*, 744 F. 2d 1387 (Utah, 1984).

⁸¹⁶ See *Souder v. McGuire*, 423 F. Supp. 830 (Penn., 1976). This case should be compared to *Price v. Sheppard*, 239 N.W. 2d 905 (Minn., 1976), where electro-convulsive therapy was found not to be "cruel and unusual punishment". The relevance of this latter decision in a Canadian context is unclear, however, as the procedure was found not to be "punishment". The comparable clause in the *Canadian Charter of Rights and Freedoms* refers to "cruel and unusual treatment or punishment." [emphasis added].

⁸¹⁷ *Application of Georgetown College*, 331 F. 2d 1009 (1964).

⁸¹⁸ *In re Osbourne*, 294 A. 2d 372 (D.C., 1972). This is also probably the law in Ontario at the time of writing: see *Molette v. Shulman* (1987), 63 O.R. (2d) 243 (H.C.), currently under appeal. That case involved an emergency blood transfusion given to a Jehovah's Witness. Although no court application was involved, the court places strong reliance on the right of the patient to refuse treatment. Particularly given the freedom of religion guaranteed by the *Charter*, it is unlikely that a Canadian court would override a patient's

would now appear to be analogous to their concern regarding treatment refusals by the elderly or terminally ill: was there a voluntary, knowing and valid refusal of the treatment.

It is in this context that competency to consent to treatment must be understood. Perhaps because a patient's competency is not normally determinative of the treatment decision which will eventually be made, there is not a great deal of case law on point.

Some courts have applied the definitions of contractual competence directly in the context of competence to consent to treatment. Thus in *In the Matter of Schiller*, for example, the court states the standard test of contractual capacity, referring to the need to understand in a reasonable manner, the nature, extent, character, and effect of the act or transaction at issue⁸¹⁹ and then paraphrases the test in a treatment context as follows:

In terms of mental capacity to consent, the test may be stated as: Does the patient have sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment, attendant risks in pursuing the treatment, and not pursuing the treatment.⁸²⁰

Other cases are not based explicitly on the common law relating to wills and contracts, but rather on a more fundamental test, the patient's rationality. Such an approach is taken by the United States Court of Appeals for the Fourth Circuit in *U.S. v. Charters*:

To determine Charters' competence, the district court should evaluate whether Charters has followed a rational process in deciding to refuse antipsychotic medication and can give rational reasons for the choice he has made. Latitude must be given in defining a "rational reason," supporting Charters' decision. For example, it would not be a competent decision based on rational reasons if Charters refused medication out of a denial that he suffers from schizophrenia or out of a belief that the drugs will have effects that no rational person could believe them to have. However, Charters' fear that if medicated he, though by no means cured, would be discharged into a less protective environment, as well as the indisputable risk that he may suffer substantial and irreversible harm, may each provide a rational basis for refusing the medication if supported by the facts. Indeed, should Charters refuse antipsychotic medication because he believes that the risks of side effects and the possibility of permanent

competent refusal of treatment, when that refusal was based on religious grounds.

⁸¹⁹ *In the Matter of Schiller*, 372 A. 2d. 360 (N.J., 1977) at 367.

⁸²⁰ *In the Matter of Schiller*, 372 A. 2d. 360 (N.J., 1977) at 367. A similar approach is taken in *Aposie v. U.S.*, 582 F. Supp. 65 (Puerto Rico, 1984).

injury outweigh the possible benefits of that medication to him, it will be difficult for him to be found incompetent by virtue of that judgment.⁸²¹

A third approach is based theoretically not on the law of contracts and wills, nor on a pure rationality test, but rather on the law regarding consent to treatment. The issue becomes whether the individual involved can adequately process the information which must be provided for informed consent. In *Riese v. St. Mary's Hospital and Medical Center*, the California Court of Appeals adopted such a test:

LPS [the relevant legislation] provides that there must be an evidentiary hearing directed to the question whether the patient is able to understand and knowingly and intelligently act upon the information required to be given regarding the treatment. ... The court is *not* to decide such medical questions as whether the proposed therapy is definitely needed or is the least drastic alternative available, but may consider such issues only as pertinent to assessment of the patient's ability to consent to the treatment.

Judicial determination of the specific competency to consent to drug treatment should focus primarily upon three factors: (a) whether the patient is aware of his or her situation (e.g., if the court is satisfied of the existence of psychosis, does the individual acknowledge that condition); (b) whether the patient is able to understand the benefits and the risks of, as well as the alternatives to, the proposed intervention ... and (c) whether the patient is able to understand and to knowingly and intelligently evaluate the information required to be given to patients whose informed consent is sought and otherwise participate in the treatment decision by means of rational thought processes. With respect to this last consideration, it has with reason been urged that "the appropriate test is a negative one: in the absence of a clear link between an individual's delusional or hallucinatory perceptions and his ultimate decision" it should be assumed "that he is utilizing rational modes of thought."⁸²²

Occasionally, cases provide some insight into what may be inappropriate criteria for assessment of competence. There is authority for the proposition that fixing a minimum age of consent for treatment, below which the consent of a parent is required for treatment, is unconstitutional.⁸²³ There is authority for the proposition that the decision to be taken by the patient is not determinative, or

⁸²¹ *U.S. v. Charters*, 829 F. 2d 479, (Virg., 1987) at 496 f. Footnotes omitted. The standard of "rationality" is also employed in *In Re Matter of O'Brien*, 517 N.Y.S. 2d 346 (1986).

⁸²² *Riese v. St. Mary's Hospital and Medical Center*, 243 Cal. Rptr. 241 (1987) at 253 f.

⁸²³ See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1975) at 72 f. This decision concerned the requirement of a Missouri statute that the consent of a parent was required for an abortion of a patient under the age of eighteen. The court comments:

Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights. [at 74.]

The court notes that children as young as ten years of age had sought abortions. It specifically holds that by striking out the parental consent provision, they were not holding that any minor could consent to abort, "regardless of age or maturity" [at 75].

even relevant in a determination of competence. Certainly, competence to consent to treatment is not to be equated with the decision a prudent patient would make, or with agreement with the advising physician.⁸²⁴

Interestingly, the case of *Lane v. Candura*⁸²⁵ considers the circumstances of the testing of competence performed by the physician, and not merely the results of that testing. That case involved a refusal by an elderly woman to consent to the amputation of a foot infected with gangrene. The physicians considered her incompetent, in part, because of her reluctance to discuss her reasons for refusing treatment. Rather than attributing this to incompetence, the court found that the patient simply did not choose to discuss the decision with the doctors. Although the patient's decision wavered, the court held that this was evidence merely that "she had vacillated in her resolve not to submit to the operation", and was not evidence of incompetence.

The various tests are phrased in differing detail in various cases. The standard of competence established in each category differs according to the precise formulation of the test. Whichever theoretical basis is used for the test, decisions are based very much on their facts, and the different tests are therefore very difficult to evaluate.

American case law is of mixed value to the Enquiry. Much American case law aims to achieve what is the status quo in Ontario, regarding adequacy of treatment, due process safeguards, and the separation of competence from institutionalization. There are some constitutional parallels, particularly in the right to liberty, and to due process; however, most clauses of the American constitution have no direct Canadian parallel, and Canadian constitutional law has not developed that closely in tandem with its American counterpart. The Canadian *Charter's* right to be free of cruel and unusual treatment or punishment is broader than the American right, which extends only to punishment, and the American constitution lacks the guarantee of freedom from discrimination on the basis of mental disability contained in the Canadian *Charter*. The *Charter* is thus likely to be more directly relevant to the issues before this Enquiry than the American constitution.

⁸²⁴ *In the Matter of Schiller*, 372 A. 2d 360 (N.J., 1977); *Lane v. Candura*, 376 N.E. 2d 1232 (Mass., 1978); *U.S. v. Charters*, 829 F. 2d 479, (Virg., 1987).

⁸²⁵ *Lane v. Candura*, 376 N.E. 2d 1232 (Mass., 1978).

American case law is relevant in its distinction between incompetence and undue influence. Until 1974, the Anglo-Canadian courts had adopted a much narrower doctrine of undue influence. After the case of *Lloyds Bank v. Bundy*⁸²⁶ in 1974, however, our courts have been much more receptive to undue influence claims. While the exact scope of the revised doctrine is not yet firm, it would appear that Canadian case law may well develop in a similar fashion to American in this regard.⁸²⁷ It is not clear whether the definition of competence outside the undue influence framework will be adjusted downwards to correspond to the American definition.

⁸²⁶ (1974) 3 All E.R. 757 (C.A.).

⁸²⁷ This will be discussed further in the section on Canadian law, below.

V. HISTORICAL DEVELOPMENTS IN CANADA

Common Law Development

Canadian case law on testamentary and contractual capacity is firmly rooted in its nineteenth century English ancestor, to the point where until recently, Anglo-Canadian courts did not draw any distinction from English law. As discussed previously, English courts of the nineteenth century created a vast array of legal principles surrounding competency determination. For the bulk of the century, judicial determination centred around the concept of delusion, which was considered the *sine qua non* of lunacy by the courts. A separate line of cases involving idiocy set a functional standard of competence, whether the subject was capable of understanding various things. The case of *Banks v. Goodfellow* in 1870 was pivotal in English law, as it combined these two strands of cases into one test, which referred both to the functional abilities of the subject, and the need for the subject's decisions to be free from the effect of delusions. As the century drew to a close, the courts became increasingly reluctant to find individuals incompetent as a result of delusions.

The Canadian case law does not appear to recognize the significance of *Banks v. Goodfellow*. While *Banks* is the most frequently cited case in the twentieth century Canadian canon, Canadian courts until very recently cited earlier English authorities with approval, without giving serious consideration to how they may have been modified by the *Banks* case. Thus in *Skinner v. Farquharson*,⁸²⁸ evidence of general incapacity is given distinctly short shrift relative to the testator's delusion that his wife and son were involved in an incestuous relationship. The definition of 'delusion' found in the 1933 case of *Re Watts* is firmly reminiscent of the nineteenth century case law and the philosophy of John Locke from which it derives:

A delusion has been defined as a false belief originating spontaneously in the imagination without foundation either in fact or evidence, of the falsity of which the person affected cannot be convinced by argument or proof.⁸²⁹

In the 1963 case of *Re Davis*, the court applied the following criteria from the 1843 English case of *Mudway v. Croft* as a major factor in the determination of the testator's competence:

⁸²⁸ *Skinner v. Farquharson* (1901), 32 S.C.R. 58.

⁸²⁹ *Re Watts*, [1933] 2 D.L.R. 800 (N.B.S.C. at A.D.) at 800.

Madness is not indicated by any particular extravagance of thought or feeling, as by a well marked change of character, or departure from the ordinary habits of thinking, feeling, and acting, without any adequate external cause.⁸²⁸

In addition, the court considers the possession of a good and complete memory as essential to testamentary capacity.⁸³¹ In this, the court cites earlier Canadian authority and nineteenth century Scots authority.⁸³² *Banks* is quoted as well; the point here is that while *Banks* increasingly became the standard test, Canadian courts continued to apply prior English case law as well.

Canadian law can be seen to reflect the full range of nineteenth century English criteria related to incompetence. Like the English cases which followed *Banks*, delusions were relevant only insofar as they affected the decision of the subject regarding the will or contract at issue.⁸³³ A "sound and disposing memory" was considered essential by some cases, as it was in the English cases such as *The Marquess of Winchester's Case*⁸³⁴ and the nineteenth century cases which followed. Citing one such case, the Supreme Court of Canada defined such a memory in 1944 in the following fashion:

A "disposing mind and memory" is one able to comprehend, of its own initiative and volition, the essential elements of will-making, property, objects, just claims to consideration, revocation of existing dispositions, and the like. ... Merely to be able to make rational responses is not enough, nor to repeat a tutored formula of simple terms. There must be a power to hold the essential field of the mind in some degree as a whole, and this I am satisfied was not present here.⁸³⁵

As with the nineteenth century English cases, which are concerned that the moral sense of the subject not be perverted by disease, the case of *Re McDonald Estate* holds that "If this disorder of his mind poisoned his affections, perverted the sense

⁸²⁸ *Re Davis*, [1963] 2 O.R. 666 (C.A.).

⁸³¹ This is also a factor given considerable weight in the case of *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 296.

⁸³² Specifically, the court cites *Murphy v. Lamphier* (1914), 31 O.L.R. 287 and *Simpson v. Gardner's Trustees* (1833), 11 Cl. of Sess. Cas. 1049. The importance of a firm memory is stressed in various nineteenth century English decisions as well, although it is less pivotal in the nineteenth century than previously.

⁸³³ See for example *Skinner v. Farquharson* (1901), 32 S.C.R. 58; *McDonald Estate, Re* (1914), 15 D.L.R. 558 (N.S. Probate); *Re Watts*, [1933] 2 D.L.R. 800 (N.B.S.C.—A.D.); *Ouderkerk v. Ouderkerk*, [1936] S.C.R. 619.

⁸³⁴ (1598), 6 Co. Rep. 23a.

⁸³⁵ *Leger and Michaud v. Poirier*, [1944] S.C.R. 152 at 161 f. The court cites not only *The Marquess of Winchester's Case*, but also *Marsh v. Tyrell and Harding* (1828), 2 Hagg. Ecc. 84 and various Canadian authorities including *Murphy v. Lamphier* (1914), 31 O.L.R. 287. For a more recent Ontario authority, see *Re Davis*, [1963] 2 O.R. 666 (C.A.) discussed above.

of right of the testator, or prevented the exercise of his natural faculties, if his insane suspicion and aversion took the place of natural affection, his will made under such circumstances should not stand.⁸³⁶ Most frequently, and directly as a result of the *Banks* case, the Canadian courts have been concerned with whether the testator understands the extent of the property to be disposed of, and his relationship to those who would have a "natural" claim on his estate.⁸³⁷ Some other cases adopt the less specific language that the subject was not capable of understanding what he or she was doing when the document was executed.⁸³⁸

The evidence introduced in matters regarding contractual or testamentary capacity has largely been similar to the evidence in English cases. The usual approach is to consider the document in the circumstances of the subject's life. In a testamentary action, prior wills are admissible and highly relevant. While it is the capacity of the subject at the time the document was executed which is at issue,⁸³⁹ evidence of competence at other times near the time of execution is also relevant. The scope of relevant evidence in a testamentary action has been explained by the Ontario Court of Appeal as follows:

While the ultimate probative fact which a Probate Court is seeking is whether or not the testator had testamentary capacity at the time of the execution of his will, the evidence from which the Court's conclusion is to be drawn will in most cases be largely circumstantial. It is quite proper to consider the background of the testator, the nature of his assets, his relatives and others having claims upon his bounty and his relationship to them, and his capacity at times subsequent to the execution of the will, to the extent that it throws light upon his capacity at the time of the making of the will. Proven incapacity at a later date obviously does not establish incapacity at the time of the execution of the disputed will, but neither is that fact irrelevant. Its weight depends upon how long after the crucial time the incapacity is shown to exist, and its relationship to matters that have gone before or arose at or near the time of the execution of the will itself.⁸⁴⁰

Notwithstanding a firm reliance on its English roots, the Canadian case law has developed the English precedents in a variety of ways. In the result, Canadian case law has developed some slightly different nuances and emphases than its English counterpart.

⁸³⁶ *McDonald Estate, Re* (1914), 15 D.L.R. 558 (N.S. Probate) at 560.

⁸³⁷ *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 318; *Romanko and Romanko v. Hawrysh and Sametz*, [1936] 3 W.W.R. 12 (Sask. C.A.); *Beal v. Henri*, [1950] O.R. 780 (C.A.). The discussion of the evidence admissible in the case of *Eady v. Waring* (1974), 2 O.R. (2d) 627 (C.A.) at 639 clearly also has the *Banks* test in mind.

⁸³⁸ See, for example, *Re Rogers, Rogers v. Rogers* (1963), 39 D.L.R. (3d) 141 (B.C.C.A.) at 145; *Anderson and Houge v. Walkley and Mason*, [1961] 1 O.R. 289 (C.A.).

⁸³⁹ Or, in the case of a will, at the time the solicitor received instructions to draw the will.

⁸⁴⁰ *Eady v. Waring* (1974), 2 O.R. (2d) 627 (C.A.), at 639.

The role of medical evidence in Canadian case law is ambiguous. On the one hand, there are indications that medical evidence has become an integral part of a case involving incompetence. As will be noted below, for a finding of incompetence under the provincial statutes, evidence of two medical professionals is required. Similarly, it is difficult to imagine a case involving testamentary or contractual capacity not including the evidence of medical professionals. The reported cases generally consider the medical evidence very seriously, and attempt to reach some understanding of the condition with which the subject is diagnosed. The association between a delusion and a finding of insanity as a medical condition is sometimes a way in which the court distinguishes between incompetence and merely erratic or eccentric behaviour, as in the following comments of Taschereau J. in *Skinner v. Farquharson*:

I fail to see on this record sufficient evidence to set aside the will in question. In the first place, it is not clear to my mind that the testator's belief that his wife had been guilty of the abominable crime in question was, at its origin, an insane delusion, however unfounded that belief was. A belief of that nature, whether founded or not, preying upon a man's mind is undoubtedly of a character to drive him ultimately to the mad house; but that he is from the beginning a madman and *non compos mentis* simply because his suspicions are unfounded seems to me an untenable proposition.⁸⁴¹

On the other hand, the distinction between medical diagnosis and a legal finding of incompetence is strictly maintained. The evidence of medical professionals is in theory no more reliable or weighty than the evidence of lay people, who may have known the subject more intimately. The *Davis* case makes the point in this way:

Whether a person has testamentary capacity, i.e., whether he has a sound and disposing mind, raises a practical question which, so far at least as evidence based on observation and experience is concerned, as contrasted with evidence based on pathological findings, may be answered by laymen of good sense as by doctors. ... Summing up to the jury [in the case of *Boughton and Marston v. Knight* (1873), 3 P & D 64] Sir J. Hannen said in part at p. 67:

I desire particularly now, and throughout the consideration which you will have to give to this case, to impress upon your minds that, in my opinion, this is eminently a practical question, one in which the good sense of men of the world is called into action, and that it does not depend solely on scientific or legal definition.⁸⁴²

⁸⁴¹ *Skinner v. Farquharson* (1901), 32 S.C.R. 58 at 59. See further *Beal v. Hewi*, [1950] O.R. 780 (C.A.), where the claim of an estranged husband that he owned part of his wife's business, and his registration of the business name under his own name under the *Partnerships Act*, was held to be the action of a malicious and disagreeable ex-husband, rather than an effect of insanity. As a result, the competence of the husband was upheld.

⁸⁴² See, for example, *Re Davis*, [1963] 2 O.R. 666 (C.A.).

The courts have taken notice of a wide variety of circumstances surrounding the execution of a will or contract to ascertain competence, and in no way are restricted by medical evidence.

More critical than medical evidence is evidence surrounding the execution of the document in question. In a case regarding testamentary capacity, for example, a marked departure from previous wills might be sufficient to raise a suspicion in the court that the testator was not competent, if the testator were known to be infirm⁸⁴³ and particularly if there are indications of pressures from beneficiaries to the will. When the court becomes suspicious, it becomes "vigilant and jealous in examining the evidence in support of the instrument, in favour of which it ought not to pronounce unless the suspicion is removed, and it is judicially satisfied that the paper propounded does express the true Will of the deceased."⁸⁴⁴ While this doctrine exists in England as well, it is generally restricted to situations where the individual who prepared or procured the will in question was also a beneficiary under it, in Canada, there is no such restriction.⁸⁴⁵

Canadian law generally follows English law regarding the presumption of competence and the onus of proof. As in English law, persons are presumed to be competent, and the onus in a contracts case will normally be on the party alleging incompetence.⁸⁴⁶ There has been some debate as to whether the grant of letters probate reverses the onus in a subsequent challenge to the testamentary capacity of the testator. The following comment from a 1961 Ontario case suggests that this issue, and indeed the issue of onus as a whole, may be of limited importance:

⁸⁴³ See *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 291 f.

⁸⁴⁴ *Anderson and Hough v. Walkey and Mason*, [1961] 1 O.R. 289 (C.A.), quoting *Barry v. Butlin* (1838), Moore P.C. 480. See also *Leger and Michaud v. Poirier*, [1944] S.C.R. 152 at 165.

⁸⁴⁵ See *Eady v. Waring* (1974), 2 O.R. (2d) 627 (C.A.) at 642 f.

⁸⁴⁶ See, for example, *Leger and Michaud v. Poirier*, [1944] S.C.R. 152; *Anderson and Hough v. Walkey and Mason*, [1961] 1 O.R. 289 (C.A.). An exception involves gifts, where the onus is on the person seeking to uphold the gift. This reasoning has been extended to appointments of individuals as preferred beneficiaries in life insurance plans and pension plans. In suits between newly appointed and former beneficiaries, and it has been held that the onus is on the person seeking to uphold the contractual designation: see *Re Rogers, Rogers v. Rogers* (1963), 39 D.L.R. (3d) 141 (B.C.C.A.), *Stewart v. Nash* (1988), 65 O.R. (2d) 218 (H.C.). In the recent British Columbia case of *Gillis v. Hulton*, [1988] B.C.J. No. 846 (B.C.S.C.), the court held that the onus of proof was on the person seeking to enforce the contract to demonstrate competence. The defence to that case was akin to a defence of undue influence, suggesting that the onus may have turned on its rather peculiar facts.

But onus as a determining factor of the whole case can only arise if the tribunal finds the evidence pro and con so evenly balanced that it can come to no sure conclusion. Then the onus will determine the matter. But if the tribunal, after hearing and weighing the evidence comes to a determinate conclusion, the onus has nothing to do with it, and need not be further considered.⁹⁷

Canadian law places a higher expectation on the persons present when a document is signed, to ensure that the signatory is competent. As the following passage from *Murphy v. Lamphier* indicates, failure of the solicitor to make reasonable enquiries which would establish competence or lack thereof can mitigate against the validity of a will:

How easy, then, for the solicitor, in the confidential moments of the private interview, if the old lady was so bright and clear and had so great a desire to alter her will, to ask why she was dividing the land and why she was leaving out her husband. How it would have cleared the air had the old lady given the reasons now suggested to explain her action ... But there was not time taken for this, and the omission of it deepens the doubts as to the worth of the will of 1912.

* * *

In Jarman's original text he wrote suggestions which are of lasting worth to persons taking instructions for wills. His first sentence is: "Few of the duties which devolve upon a solicitor, more imperatively call for the exercise of a sound, discriminating, and well-informed judgment, than that of taking instructions for wills;" and his last sentence is a quotation from Sir John Nicholl, to the effect that, where instructions are given by an interested party, it is the bounden duty of the solicitor to satisfy himself thoroughly as to the testator's volition and capacity, or, in other words, that the instrument expresses the real testamentary intentions of a capable testator, prior to its being executed *de facto* as a will at all.

That last caution is of equal significance when the testator is in a state of mental or physical decrepitude, or there is for any cause some reason to doubt of his being of mind and memory sufficient for the transaction.⁹⁸

Canadian cases are similar to the English in that, at least until recently, there are relatively few reported cases based on the doctrine of undue influence exercised upon marginally competent individuals. The distinction between Anglo-Canadian and American law in this regard is clear when the facts in the case of *Murphy v. Lamphier* are considered:

What, then, are the things out of the common which invite the inspection and consideration of the Court? In brief outline, these: (a) the will is made during the temporary absence of Mrs. Lamphier from her husband; (b) made without reference to or communication with her natural protectors; (c)

⁹⁷ *Anderson and Hough v. Walkley and Mason*, [1961] 1 O.R. 289 (C.A.).

⁹⁸ *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 315 f., 319; cited with approval in *Re Davis*, [1963] 2 O.R. 666 (C.A.). The court in *Murphy* requires that regarding persons needing protection and advice, it is important to find out if there is a former will, and its nature, with a view to getting at the reasons for any variation or changes: at 320.

made whilst she was in the hands and under the care of two married daughters who were dissatisfied with a former will and had recently sought to have it changed; (d) made by an old lady verging on eighty years of age, suffering under a double process of deterioration from the impairments of senility and the inroads of a progressive disease affecting her brain; (e) made by a solicitor who could not be regarded as an independent adviser and who was not chosen by the testatrix; (f) made on the spur of the moment, where the method of testamentary disposition, originating nine years before and carried through a series of wills down to the one made in 1911, was displaced and superseded by a method of equal distribution desired by Mrs. Brown and Mrs. Hayes and the other dissentients.⁸⁴⁹

The court goes on to find, in effect, that undue influence was in fact practised on the testatrix by her daughter,⁸⁵⁰ yet the case was pleaded in incompetence, not undue influence.

The reasons are several. Firstly, the onus in a case of undue influence is upon the party alleging the undue influence. In a testamentary suit, this will be the party challenging the will. There is thus a systemic bias in favour of challenging on the basis of competence, where the other party will have the onus of proof.⁸⁵¹ This distinction does not arise under American law, where the party challenging the will has the onus in any event. Secondly, until relatively recently, the courts have been reluctant to make a finding of undue influence in the Anglo-Canadian law, sometimes expecting highly persuasive evidence, the substance of which would border on an indication of malicious intent, as the following passage from the 1961 case of *Anderson and Houge v. Walkey and Mason* would suggest:

There is no doubt that a cause of action based on fraud and undue influence may be made out on the basis of indirect or circumstantial evidence alone, but in order to set aside the will of a person of sound mind, it must be shown that the circumstances under which it was executed are inconsistent with any hypothesis but that of undue influence which cannot be presumed but must be shown to have been exercised, and exercised in relation to the will itself. Nothing is to be imputed to the defendant that is not proved against her.⁸⁵²

The court continues by finding that the evidence does not indicate that the defendant was "entertaining a sinister plot to cheat the natural object of a testator's bounty out of her inheritance."⁸⁵³ Finally, the factors which would give rise to a claim of undue influence also give rise to the "suspicious circumstances" discussed

⁸⁴⁹ *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 307 f.

⁸⁵⁰ *Murphy v. Lamphier* (1914), 31 O.L.R. 287 at 314.

⁸⁵¹ See *Stewart v. Nash* (1988), 65 O.R. (2d) 218 (H.C.).

⁸⁵² *Anderson and Houge v. Walkey and Mason*, [1961] 1 O.R. 289 (C.A.).

⁸⁵³ *Anderson and Houge v. Walkey and Mason*, [1961] 1 O.R. 289 (C.A.).

above, where the onus will be very difficult for the individual propounding the will to discharge.⁸⁵⁴

Since the case of *Lloyds Bank v. Bundy*,⁸⁵⁵ the doctrine of undue influence has become broader in the Anglo-Canadian tradition, and there has been a fresh interest in the doctrine as it applies to the marginally competent. Recent cases are remarkably similar to American case law on the issue. There must be a transfer for inadequate consideration; and either a relationship of dependence or a confidential or fiduciary relationship between the parties. In that situation, a rebuttable presumption of undue influence arises.⁸⁵⁶ There is now authority, following *Bundy*, that the failure to provide independent legal advice in such situations may raise a high presumption of undue influence,⁸⁵⁷ and it is increasingly clear that the courts are more ready to make a finding of undue influence than in the days of *Anderson*. It may well be that the doctrine of undue influence will become increasingly important in Canadian law regarding competence.

Canadian Statutes: Historical Development

The statutory framework of Canadian law presents something of the same problem as American law. Matters of civil law, including contractual and testamentary law, lunacy law, and health law in general, are primarily in the provincial jurisdiction. Canadian law is not consistent across the ten provinces and two territories. To further complicate matters, the law regarding persons found not guilty by reason of insanity or unfit to stand trial is largely, although perhaps not exclusively, within the federal jurisdiction.⁸⁵⁸ As in the United States, however, general comments can be made as to the nature of the Canadian statutes.

⁸⁵⁴ This was in fact what occurred in *Murphy v. Lamphier*.

⁸⁵⁵ *Lloyds Bank v. Bundy* (1974), 3 All E.R. 757 (C.A.).

⁸⁵⁶ See, for example, *Marshall v. Canada Permanent Trust* (1968), 69 D.L.R. (2d) 260 (Alta. S.C.); *Shoop v. Tanner* [1986] S.J. No. 678 (S.C. Sask.); *Gannon v. Steeves*, [1987] N.B.J. No. 1046 (C.A.); *Stewart v. Nash* (1988), 65 O.R. (2d) 218 (H.C.).

⁸⁵⁷ *Gannon v. Steeves*, [1987] N.B.J. No. 1046 (C.A.) at p. 9f.

⁸⁵⁸ The major provisions concerning persons found not guilty by reason of insanity and unfit to stand trial are contained in the *Criminal Code*, R.S.C. 1985, c. C-42. These individuals are dealt with primarily by the Lieutenant Governor's Board of Review, a provincially appointed body established under the provisions of the *Criminal Code*. The Ontario *Mental Health Act*, R.S.O. 1980, c.262, does purport to affect persons detained under the *Code*, particularly as regards treatment: see s.35c. The constitutionality of these provisions has not been tested, but is under consideration in *R. v. Swain*, S.C.C. File No. 19758, on appeal to the Supreme Court of Canada.

A survey of the development of the law of Ontario provides a framework against which the law of other provinces may be compared. Under colonial law, some but not all English statutes affected Upper Canada.⁸⁵⁹ The statutes which were effective included *De Prerogativa Regis*, a number of imperial statutes concerning the management of the estates of persons found incompetent, and the 1742 *Act* by which marriages of persons found lunatic by inquisition were void *ab initio*. These statutes continued to be effective in Ontario after confederation. Relevant excerpts were actually re-enacted in the supplement to the Consolidated Statutes of Ontario at the end of the nineteenth century.⁸⁶⁰

As we have seen, the English law gave custody of fools and lunatics to the King as part of the Royal Prerogative power. The jurisdiction was in practice exercised by the Lord Chancellor, and later by judges of the Court of Chancery. They did not have any inherent jurisdiction to exercise this power, but were granted the authority by the King through a special commission under the sign manual. This led to some confusion in Upper Canada as to who could exercise the jurisdiction, as it was unclear how the provisions of the sign manual applied. These doubts were eradicated in 1846, when a statute of Canada conferred the jurisdiction specifically on the Judges of the Court of Chancery in what had formerly been Upper Canada.⁸⁶¹ This *Act* also contained a variety of provisions relating to the management of estates and procedure for the conduct of inquisitions. Presumably again for further certainty, and typical of other early Canadian statutes dealing with the determination of lunacy, "lunatic" was defined as including "an Idiot or other person of unsound mind."⁸⁶² The procedures regarding inquisitions in lunacy were simplified in 1857, so that a full procedure would only be invoked when there was

⁸⁵⁹ The area which is now southern Ontario was variously known as Upper Canada, and Canada West. For part of the nineteenth century, what is now southern Ontario and southern Quebec were united into one province, simply called Canada.

⁸⁶⁰ See, for example, *An Act Respecting Lunatics* (2), C.S.O. 1897, c.341.

⁸⁶¹ See *An Act to remove certain doubts as to the jurisdiction conferred upon the Court of Chancery in Upper Canada, in matters relating to Lunatics, Idiots, and persons of unsound mind, and their Estates*, 9 Victoria (1846), c.10.

⁸⁶² *Ibid.*, s.1. Consistent with English law of the period, it would not have been necessary to demonstrate that a respondent came within one of the narrowly defined classes of lunacy, defined prior to the nineteenth century by the common law. See also, for example, *Lunatics' Estates Act*, S.A. 1916, c.11, s.1.

reasonable doubt as to the lunacy of the respondent.⁸⁶³ The provisions of the 1846 and 1857 Acts were incorporated into the *Court of Chancery Act, 1859*.⁸⁶⁴

The full inquisition procedure was abolished in 1865, when trials of lunacy took a form very similar to other civil proceedings. The requirement of a jury trial also ceased at this time, although the respondent continued to have the right to require the issue of incompetence to be tried by a jury.⁸⁶⁵

The portions of the *Court of Chancery Act* involving determinations of lunacy were separated from that Act in 1887, into what was really Ontario's first *Lunacy Act*.⁸⁶⁶ The provisions of that Act were not in themselves new; it was their separation from the more general statute which represented something of a departure. Until the enactment of the *Lunacy Act, 1909*,⁸⁶⁷ however, the procedures operated in concert with the inherited English law.

Unlike the laws regarding inquisitions in lunacy, the English poor laws were not effective in Ontario, and, therefore, the English statutes regarding the construction of and admission to lunatic asylums did not apply here. Nonetheless, Ontario did not lag far behind England in beginning to develop a system of asylums. The first statutory concern with the care and maintenance of lunatics created a tax for the maintenance and support of insane destitute persons in 1830.⁸⁶⁸ It did not require the construction of a lunatic asylum. That step occurred in 1839,⁸⁶⁹ a mere thirty-one years after the authority to raise money for asylums through taxation was granted in England, and seven years before the construction

⁸⁶³ See 20 Victoria (1857) c.56, s.5. The descendent of this provision is still contained in the *Mental Incompetency Act*, R.S.O. 1980, c.264, s.7(1), which allows the court to make a finding of mental incompetence without ordering a trial of the issue, when material filed with the application establishes the incompetence beyond a reasonable doubt.

⁸⁶⁴ *Court of Chancery Act*, 22 Victoria (1859), c.12, sections 31 sq.

⁸⁶⁵ *An Act to Amend the Consolidated Statute respecting the Court of Chancery*, 28 Victoria (1865) c.17, s.5. The right of the respondent to require that the issue of incompetence be tried by a jury continues as section 9 of the *Mental Incompetency Act*.

⁸⁶⁶ *An Act respecting Lunatics*, 50 Victoria (1887) c.54.

⁸⁶⁷ *Lunacy Act* (Ontario), 9 Edward VII (1909), c.37.

⁸⁶⁸ *An Act to authorize the Quarter Sessions of the Home District to provide for the relief of insane destitute persons in that District*, 11 George IV (1830), c.20.

⁸⁶⁹ *An Act to authorise the erection of an Asylum within this Province, for the reception of Insane and Lunatic persons*, 2 Victoria (1839), c.11.

of county asylums became mandatory in England. The 1839 statute also included the province's first committal criteria. Certificates from three qualified medical practitioners were required, attesting to the fact that the subject was in fact a lunatic.⁸⁷⁰

At the end of the nineteenth century, the English poor law statutes relating to the establishment and management of, and admission to, lunatic asylums were consolidated with the statutes regarding criminal lunatics and inquisitions in lunacy.⁸⁷¹ Ontario law never made such a consolidation, and to this day has separate statutes regarding the establishment of asylums, the standards for admission to asylums, and the determination of mental competency generally.

Other provinces modelled their lunacy legislation in the nineteenth century on the law of England in much the same fashion as Ontario. Following English common law authority,⁸⁷² for example, a number of provinces required that an individual be actually dangerous before they might be committed. The Nova Scotia *Act*, for example, required "circumstances denoting a derangement of mind and a purpose of committing [sic] some crime for which if committed the person would be liable to be indicted."⁸⁷³ Even more indicative of the reliance on English law is the enactment of the British Columbia *Lunacy Act* in 1897. The *Act* was apparently included in the Revised Statutes of that year by the commissioners revising the statutes, as part of their mandate to "insert emendations and additional *Acts* where desirable". The *Act* was modelled directly on portions of the 1890 English *Act*, and passed when the revised statutes were adopted in 1897.⁸⁷⁴

The *Acts* did not mirror their English models in all respects. Canadian lunacy statutes never included the wide variety of administrative provisions, ranging

⁸⁷⁰ s.6.

⁸⁷¹ See *Lunacy Act 1890*, 53 Victoria (1890) c.5.

⁸⁷² See, for example, *Nottidge v. Ripley*, (1849, Middlesex Nisi Prius).

⁸⁷³ *Insanity Act*, R.S.N.S. 1900, c.125. The provision is still in force for judicial committals under the *Incompetent Persons Act*, R.S.N.S. 1967, c.135: see s.17. It would appear that this section is virtually never used, and that virtually all committals in Nova Scotia now take place under the less onerous provisions of the *Public Hospitals Act*, R.S.N.S. 1967, c.249. A similar standard to that quoted was in force briefly in British Columbia: *Insane Asylums Act Amendment Act*, 56 Victoria (1893) c.18, s.4. That standard in British Columbia was relatively quickly replaced by the requirement merely that an individual be "insane and dangerous to be at large": *Lunacy Act*, 60-61 Victoria (1897) c.17, s.13. This was also the standard adopted in Alberta in 1907: *v. Insanity Act*, S.A. 1907, c.7, s.2.

⁸⁷⁴ See *Lunacy Act*, 60-61 Victoria (1897), c.17.

from diet to religious observances to restrictions on the use of restraint, that the English law developed.

The *Acts* concerning asylums and committal, from an early date, made a connection between institutionalization and the control of the patient's estate by the state. The 1907 Alberta statute, for example, contained the following additional inquiry for persons who were civilly committed:

If the justice is satisfied that the person so apprehended as aforesaid is insane and dangerous to be at large, [i.e., civilly committable] he shall also make inquiry as to the nature and particulars of such person's property, as to the number of persons if any who are dependent upon him for support, and as to all other matters mentioned in form E in the schedule to this Act so that it may be ascertained whether such person should be sustained as an insane pauper or not.⁸⁷⁵

By 1916, the Administrator of Lunatics' Estates became statutory committee of all persons detained in Alberta psychiatric facilities.⁸⁷⁶ In British Columbia, the superintendent of the asylum was committee of the estates of persons detained in the asylum as early as 1897, and in Ontario by 1887.⁸⁷⁷ Institutionalization was not sufficient for a finding of lunacy under the general incompetency statutes,⁸⁷⁸ however, leaving the Public Trustee largely unchallengeable in his administration of the estate.

This association between committal and automatic deprivation of right to manage one's estate did not cease until the mid to late 1960s. While the move away from this system is frequently associated with the rise of civil rights for psychiatric patients, it is interesting to note that the move occurred within a few years following the introduction of universal health care, with the corresponding reduction in individual liability for care.

A number of statutes regarding inquisitions in lunacy are fundamentally unchanged since the nineteenth century. A particularly clear example is the Nova Scotia *Incompetent Persons Act*⁸⁷⁹ which, apart from a name change and the

⁸⁷⁵ S.A. 1907, c.7, s.6.

⁸⁷⁶ *Lunatics' Estates Act*, S.A. 1916, c.11, s.3. Consolidated as R.S.A. 1922, c.225, s.4.

⁸⁷⁷ See *Lunacy Act* (British Columbia), 60-61 Victoria (1897), c.17, and *An Act respecting Lunatics* (Ontario), 50 Victoria (1887), c.54.

⁸⁷⁸ See for example *Re Young*, [1942] O.R. 301 (Ont. C.A.).

⁸⁷⁹ R.S.N.S. 1967, c.135.

introduction of a not very useful definition of "insane person" or "lunatic", has remained virtually unchanged since the turn of the century.⁸⁸⁰

The current Ontario *Mental Incompetency Act* dates from 1909, when it was passed under the title *Lunacy Act*.⁸⁸¹ The *Act* at that time was not really new, but largely a consolidation of existing law. The nineteenth century definition of "lunatic" was incorporated directly into the statute. The inherited English law, which had been re-enacted in Ontario in 1897,⁸⁸² was repealed. The portions involving management of the estate were re-enacted in the new statute. The portions which were drawn from *De Prerogativa Regis* were not re-enacted, but instead the following provision was inserted:

- 3 (1) Subject to the provisions of *The Act respecting Lunatic Asylums and the custody of Insane Persons*, the Court shall have all the powers, jurisdiction and authority of His Majesty over and in relation to the persons and estates of lunatics, including the care and commitment of the custody of lunatics and of their persons and estates.⁸⁸³

This section refers to the royal prerogative powers, and may be taken as continuing them in the 1909 statute.⁸⁸⁴

In 1911, the *Lunacy Act* was expanded to include those who "through mental infirmity, arising from disease, age or other cause, or by reason of habitual drunkenness or the use of drugs, [is] incapable of managing his affairs."⁸⁸⁵ At a time when "lunatic" was defined merely as including idiots and persons of unsound mind,⁸⁸⁶ the effect of the 1911 amendment was clear. It was a further step away

⁸⁸⁰ Compare with *Lunacy Act*, R.S.N.S. 1900, c.125. The portions of the *Act* involving inquisitions in lunacy are also essentially similar to R.S.N.S. 1884, c.38. Compare also with Prince Edward Island *Mental Health Act*, R.S.P.E.I. 1974, c. M-9, s.30 sq., with S.P.E.I. 15 Victoria (1852) c.36, cited in *Re Dymet*, [1986] P.E.I.J. No. 73.

⁸⁸¹ *Lunacy Act*, (Ontario) 9 Edward VII (1909) c.37.

⁸⁸² as *An Act Respecting Lunatics* (2), C.S.O. 1897, c.341.

⁸⁸³ Apart from the substitution of the *Mental Health Act* for the *Act* indicated in the section and the substitution of "mentally incompetent persons" for "lunatics", the identical section is contained in the *Mental Incompetency Act*, R.S.O. 1980, c.264, s.4(1).

⁸⁸⁴ See *Wright v. Wright and Guarantee Trust Co.*, [1951] S.C.R. 728, which would suggest that the Ontario *Act* is to be read in conjunction with the existing common law including Royal Prerogative powers. See also *Re Eve* (1986), 13 C.P.C. (2d) 6 at 24 ff.

⁸⁸⁵ See *Lunacy Law Amendment Act* (Ontario), 1 George V, c.20.

⁸⁸⁶ See *Lunacy Act* (Ontario), 9 Edward VII (1909) c.37, s.2(e).

from the rigid definitions of lunacy which had held sway in the history of common law. The case of *Peel v. Peel*, for example, holds that absent "mental disease", an individual could not be found to be of unsound mind. The case also relies on a very narrow definition of "idiot", derived from the fourteenth century statute of *De Prerogativa Regis*. The understanding in *Peel* is that the 1911 amendments are to allow intervention absent such rigidly defined situations.⁸⁸⁷

In 1937, the *Act* was again amended. The nomenclature was changed from "lunatic" and "lunacy" to "mentally incompetent person" and "mental incompetency", and the following definition was substituted for the 1909 definition of "lunatic":

1 (c) "mentally incompetent person" means a person,

- (i) in whom there is such a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, or
- (ii) who is suffering from such a disorder of the mind,

that he requires care, supervision and control for his protection and the protection of his property.⁸⁸⁸

This definition creates a significant area of overlap with the 1911 amendment, which was not revoked. They are presumably two classes, as the individuals dealt with under the 1911 amendments must specifically be "not declared to be mentally incompetent".⁸⁸⁹ It is not at all clear how these two classes are to fit together, however, and it is perhaps wisest to treat the distinction as a historical anomaly. Apart from a few minor administrative changes, the Ontario *Mental Incompetency Act* has not been amended since that time.

The late 1930s created something of a legislative flurry regarding mentally incompetent persons and mental defectives in Canada, again reflecting the legislative interest in England at the time. The statutes passed at the period tended to take greater cognizance of the medical models of insanity and mental

⁸⁸⁷ See *Peel v. Peel* (1912), 3 D.L.R. 697 (Ont. H.C.). Given earlier English decisions such as *Ridgway v. Darwin* (1802), 8 Ves. Jr. 55 and *Ex p. Cranmer* (1805), 12 Ves. Jr. 445, it is not entirely clear why the Ontario court took such a narrow view of the term "lunatic". Other Canadian courts applied the broader English definition: see, for example, *Re Tupper* (1918), 44 D.L.R. 85 (N.S.S.C.).

⁸⁸⁸ This definition is now contained as R.S.O. 1980, c.264, s.1(e).

⁸⁸⁹ R.S.O. 1980, c.264, s.39(1). The same two classes occur in the statutes of other provinces with similar legislative histories; see, for example, the *New Brunswick Infirm Persons Act*, C.S.N.B. 1973, c. 1-8; and the *Saskatchewan Mentally Disordered Persons Act*, C.S.S. c. M-14. The Saskatchewan statute does not include the revised, 1937 definition of "mentally incompetent person", and therefore the overlap is minimized.

defect. Such a shift is arguably present in the revised definition of "mentally incompetent person" in the Ontario legislation, which was a typical definition of the period.⁸⁹⁰ It is more clearly visible in the revised committal standards of the period. These statutes merely required that the individual be mentally ill, and require care and maintenance in a psychiatric facility.⁸⁹¹

The 1960s and 1970s have the reputation of introducing civil rights into Canadian psychiatric facilities. This is certainly true regarding standards of committal. By the end of the 1970s, the norm was to have some form of dangerousness test as the requirement of civil committal. In addition, the linkages between institutionalization and loss of control of one's estate had been weakened. Now, in general, only those persons found by one or more attending physicians to be incompetent to manage their estates are placed under the jurisdiction of the Public Trustee.⁸⁹²

Particularly at the beginning of this period, however, the laws did not directly affect the actual regulation of activity in psychiatric institutions, which was to be left to the administrator of the facility. In most mental health statutes, this was simply understood. In the British Columbia *Act*, it was specified in the following terms:

Every patient detained in the Provincial mental health facility is, during detention, subject to the direction and discipline of the director and the members of the staff of the Provincial mental health facility authorized in that behalf by the director.⁸⁹³

This was also the case in Ontario until 1978, when revisions to the *Mental Health Act* began to regulate treatment and file access. The present definition of "mentally competent", to be discussed further below, was introduced in the Ontario *Act* at that time.

⁸⁹⁰ See, for example, *Mental Defectives Act Amendment Act*, 1937, S.A. 1937, c.46, s.2.

⁸⁹¹ See, for example, S.B.C. 4 George VI (1940) c.27, s.9(3).

⁸⁹² The law of Quebec continues to have the rather unusual provision that the Public Curator generally becomes committee both of the person and of the estate of mental patients found incompetent to manage their estate. This does not extend to actual custody of the individual, and does not apply when there is a guardian of the person specifically appointed: see *Public Curatorship Act* C.S.Q., 1977 c. C-80, s.7. The statute does not indicate what powers flow from the grant of committeehip of the person to the Public Curator, but it has been argued that it may include the power to consent to treatment on behalf of the patient: see H.S. Savage and C.A. McKague *Mental Health Law in Canada* (Toronto: Butterworths, 1987) at 107.

⁸⁹³ *Mental Health Act*, S.B.C. 1964, c.29, s.29.

The revisions of the 1960s and 1970s did not generally extend to amending the statutes regarding mental competence to any degree. The sole significant exception is the Alberta *Dependent Adults Act*,⁸⁹⁴ which will be discussed below.

A number of new statutory directions have been introduced in the last ten years. At least three provinces have introduced legislation which in specified circumstances allows a power of attorney to survive a finding that an individual is not competent to manage his or her estate.⁸⁹⁵ Other statutes have introduced the power to designate the person who will make treatment decisions for the individual, in the event that the individual becomes incompetent.⁸⁹⁶ In British Columbia, it has been possible since the early 1960s to designate a preferred committee in the event that a court appointment is made under the *Patients Property Act*.⁸⁹⁷

In addition, there has been a growing awareness of the multi-cultural nature of Canadian society. This has manifested itself in statutes related to competency and in the exercise of the *parens patriae* power particularly as regards Native Canadians. In the *Mental Health Act* of the Northwest Territories, for example, a physician considering civil committal of a Native Canadian is to discuss the matter with the person's elder, if the person consents to that discussion.⁸⁹⁸ In Ontario law, native bands have become increasingly involved in the exercise of the state's *parens patriae* jurisdiction over children.⁸⁹⁹

There is a growing articulation of the rights of patients, particularly in matters of psychiatric treatment, absent the judicial appointment of a guardian or committee. Competent patients in Ontario and Nova Scotia enjoy an absolute right to consent to or refuse psychiatric treatment.⁹⁰⁰ In Quebec, apparently, the right

⁸⁹⁴ *Dependent Adults Act*, S.A. 1976, c.63. Consolidated as C.S.A. 1980, c. D-32.

⁸⁹⁵ See *Powers of Attorney Amendment Act*, S.O. 1983, c.74; *Power of Attorney Act*, as amended by S.B.C. 1979, c.2, s.52; *Powers of Attorney Act*, S.N.S. 1988, c.17.

⁸⁹⁶ See particularly *Medical Consent Act*, S.N.S. 1988, c.14. The limited power to appoint a substitute for psychiatric and related medical treatment is contained in the Ontario *Mental Health Act*, R.S.O. 1980, c.262, at. 1a, 1b, and 1c. These amendments were introduced in the S.O. 1987, c.37, s.2.

⁸⁹⁷ See R.S.B.C. 1979, c.313, s.9.

⁸⁹⁸ Northwest Territories *Mental Health Act*, S.N.W.T. 1985, c.6 (2d), s.8(2).

⁸⁹⁹ See *Child and Family Services Act*, S.O. 1984, c.55.

⁹⁰⁰ See Ontario *Mental Health Act*, R.S.O. 1980, c.262, s.35(2)(a), as amended by S.O. 1987, c.37, s.11; Nova Scotia *Public Hospitals Act*, R.S.N.S. 1967, c.249, s.46(1), as amended by S.N.S. 1977, c.45, s.8. In Ontario,

of a psychiatric patient to consent to or refuse treatment, absent court intervention, is based on his or her capacity to manage his or her estate.⁹⁰¹ In the Northwest Territories, treatment in a psychiatric facility may not be performed without the consent either of the competent patient or the nearest relative of the patient.⁹⁰² In the Yukon, voluntary patients appear to have the right to consent to treatment, and involuntary patients would also appear to have this right except where the treatment is necessary to preserve the life or the mental or physical health of the patient, and failure to give the treatment would create a reasonably foreseeable risk of injury to the person or another.⁹⁰³ In Saskatchewan, the framework is more complex. The general rule is that institutionalization does not affect the civil rights of the patient, unless the *Mental Health Services Act* requires otherwise.⁹⁰⁴ Voluntary patients have a specifically enumerated right to consent to or refuse treatment.⁹⁰⁵ Involuntary patients are to be involved as far as possible in their treatment, but do not have a right to consent to treatment.⁹⁰⁶ The criteria for involuntary status, however, require *inter alia* that "as a result of the mental disorder the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision".⁹⁰⁷ This would suggest that an element of incompetence must be demonstrated before an individual can become an involuntary patient.

the right of a competent patient to consent to or refuse treatment under the *Mental Health Act* is effective even if a committee has been appointed under the *Mental Incompetency Act*.

⁹⁰¹ See H.S. Savage and C.A. McKague *Mental Health Law in Canada* (Toronto: Butterworths, 1987), at 107. If one understands that consent to medical treatment is in the jurisdiction of the tutor (guardian) under Quebec law, this would seem to be the effect of *Public Curatorship Act*, C.S.Q., 1977 c. C-80, s.7 and *Mental Patients Protection Act*, C.S.Q., 1977 c. P-41, ss. 8, 10.

⁹⁰² Northwest Territories *Mental Health Act*, S.N.W.T. 1985, c.6(2d), s.21.

⁹⁰³ Yukon *Mental Health Act*, R.S.Y. 1986, c.115, s.7. The *Act* also allows for court ordered medical treatment: s.3.

⁹⁰⁴ *Mental Health Services Act*, S.S. 1984-85-86, c. M-13.1, s.14.

⁹⁰⁵ *Ibid*, s.25(1).

⁹⁰⁶ *Ibid* at s-s. 25(2)-(4). These subsections allow treatment without any consent, so long as the treatment is "in accordance with special procedures prescribed for that treatment."

⁹⁰⁷ *Ibid* at s-s. 24(2)(a)(ii).

In other provinces, there are systems of overriding the wishes of a competent patient through the use of a review board. The factors considered by the board are normally some variant of a best interests test.⁹⁰⁸

In British Columbia, by comparison, the following provision of the *Mental Health Act* effectively deprives all involuntary patients of the right to consent to treatment:

25.2 Where a person is detained in a Provincial mental health facility under section 20, 23, 24, 25, 25.1, or 36, and notwithstanding that no order respecting the person has been made under the *Patients Property Act*, treatment authorized by the director shall be deemed to be given with the consent of the person.⁹⁰⁹

It is not clear whether, absent consideration of competence in treatment matters and appropriate due process safeguards, this section will survive scrutiny under sections 7 and 15 of the *Charter*.

The common law in Canada is that there is no specific minimum age of consent for purposes of treatment. The leading Ontario case involves an acne treatment which resulted in a burn. At issue was whether an individual under the age of majority, then twenty-one years, could consent. The court, quoting the following passage from Lord Nathan on *Medical Negligence*, held that he could:

It is suggested that the most satisfactory solution of the problem is to rule that an infant who is capable of appreciating fully the nature and consequences of a particular operation or of particular treatment can give an effective consent thereto, and in such cases the consent of the guardian is unnecessary; but that where the infant is without that capacity, any apparent consent by him or her will be a nullity, the sole right to consent being vested in the guardian.⁹¹⁰

⁹⁰⁸ See, for example, *Alberta Mental Health Act*, S.A. 1988, c. M-13.1, s.29, and *Manitoba Mental Health Act*, R.S.M. 1987, c. M110, s.25(1), as amended by R.S.M. 1987 Supp., c.23, s.7. The override in the Manitoba legislation applies only to involuntary patients, and only for psychiatric treatment.

⁹⁰⁹ *British Columbia Mental Health Act*, R.S.B.C. 1979, c.256, s.25.2, as amended by S.B.C. 1981, c.21, s.10 and S.B.C. 1985, c.12, s.10. the *Yukon Mental Health Act*, R.S.Y. 1986, c.115 provides that persons detained in psychiatric facilities may be treated without their consent pending court approval if the treatment is given or authorized by an authorized medical practitioner, if it is necessary to preserve the life or mental or physical health of the individual, and if failure to treat would create a reasonably foreseeable risk of injury to the person or to another person: see s.7(1) Court approval is required outside such emergency situations: s.7(2).

⁹¹⁰ *Johnston v. Wellensley Hospital et al* [1971], 17 D.L.R. (3d) 139 (H.C.) at 145.

A similar result has been reached in the more controversial area of contraceptive treatment by the Alberta Court of Appeal, following the leading British authority.⁹¹¹

This common law position has been modified in Ontario by the *Mental Health Act*, which creates a rebuttable presumption of incompetence for individuals between twelve and sixteen years of age.⁹¹² A regulation under the *Public Hospitals Act* purports to limit surgical intervention on persons under the age of sixteen, although this regulation is of very dubious validity.⁹¹³

While there is some Canadian case law which affirms the right of a patient to view his or her clinical record,⁹¹⁴ Canadian statutes tend to provide very little assistance regarding competence as it relates to the release of the clinical record to the patient or to third parties with the patient's consent. A number of statutes provide for the confidentiality of health records, and limit disclosure absent the consent of a competent patient.⁹¹⁵ In some provinces including Ontario, the competent patient has a qualified right to view their own clinical record.⁹¹⁶ In other jurisdictions, disclosure to a competent patient or pursuant to the request of a

⁹¹¹ See *J.S.C. and C.H.C. v. Wren* (1986), 49 Alta. L.R. (2d) 289; following *Gillick v. West Norfolk and Wisbech Area Health Authority and Another*, [1985] 3 All E.R. 402 (H.L.), discussed elsewhere in this report. Note however that the British Columbia Supreme Court held, albeit almost twenty years ago, that censure by the College of Physicians of a physician prescribing birth control devices to a fifteen-year-old would not be overruled by the courts: see *Re "D" and Council of the College of Physicians and Surgeons of British Columbia* (1970), 11 D.L.R. (3d) 570.

⁹¹² R.S.O. 1980, c.262, sections 1d, 35, and 35b, as amended by S.O. 1987, c.37.

⁹¹³ See R.R.O. 1980, Reg. 865, as amended. See further discussion of authority for this regulation elsewhere in this report.

⁹¹⁴ See, for example, *Lindsay v. M.* (1981), 121 D.L.R. (3d) 261 (Alta. C.A.); *Re Mitchell and St. Michael's Hospital* (1980), 29 O.R. (2d) 185, 112 D.L.R. (3d) 360 (H.C.). The latter case found that the patient has an interest somewhat akin to a property interest in his or her clinical record. See also *Re Abel and Advisory Review Board*, (1980), 56 C.C.C. (3d) 153 (Ont. C.A.) which recognized that patients have a right to see the information before the Review Board.

⁹¹⁵ See for example *Nova Scotia Public Hospitals Act*, R.S.N.S. c.249, s.63; *Northwest Territories Mental Health Act*, S.N.W.T. 1985, c.6(2nd), s.48(3)(a), *Ontario Mental Health Act*, R.S.O. 1980, c.262, s.29(3)(a).

⁹¹⁶ See *Ontario Mental Health Act*, R.S.O. 1980, c.262, s.29a(1), as amended by S.O. 1987, c.37, s.5(1) and *Manitoba Mental Health Act*, R.S.M. 1987, c. M110, s.26.9, as amended by R.S.M. 1987 Supp., c.23, s.7. See also, for example, *Nova Scotia Public Hospitals Act*, R.S.N.S. 1967, c.249, s.63 as amended, which appears to have a similar effect, although the right of the facility to refuse disclosure when not in the (undefined) "best interests" of the patient is a severe curtailment of this *prima facie* right of disclosure.

competent patient is within the discretion of the keeper of the file.⁹¹⁷ The statutes do not provide any useful guidance as to how competence in matters of file release are to be determined. Some statutes also provide a right to view the clinical record or parts thereof preparatory to attending a review board hearing.⁹¹⁸ In the event that the hearing will determine detention, treatment, or another issue within the purview of section 7 of the *Charter*, the right to view the evidence to be presented by the opposing party may be a constitutional right.⁹¹⁹

Provisions of Specific Statutes

Ontario statute law contains two notable definitions of mental competency. The definition in the *Mental Incompetency Act* was cited above. It is typical of the definitions enacted in the late 1930s. The definition in that *Act* reflects the concern for the protection of the individual which was the prevalent concern of the legislators at the time. Recall that what is required under this statute is some disorder of or incomplete development of the mind, such "that he requires care, supervision and control for his protection and the protection of his property".⁹²⁰ The difficulty in reconciling this definition with an apparently separate class of persons who are "through mental infirmity, arising from disease, age or other cause, or by reason of habitual drunkenness or the use of drugs, incapable of managing [their] affairs" has already been noted. It is also not entirely clear from the words of the statute what evidence is to be considered relevant for the determination. Is this to be a result-based test? Is it the ability of the individual which is at issue, rather than the result? Is it the danger of undue influence which is to be of concern to the court? The statute itself does not adequately address these problems.

⁹¹⁷ See, for example, *Alberta Mental Health Act*, S.A. 1988, c. M-13.1, s.17; and the Northwest Territories *Mental Health Act*, S.N.W.T. 1985, c.6(2nd), s.48(3)(a).

⁹¹⁸ See, for example, the *Ontario Mental Health Act*, R.S.O. 1980, c.262, s.33d, which provides an absolute right to view all documents which will be relied upon by the opposing party at the review board hearing.

⁹¹⁹ Section 7 provides the right to life, liberty, and security of the person and the right not to be deprived thereof except in accordance with fundamental justice. The dictates of fundamental justice include procedural fairness, which in turn includes the right to view relevant documentary material, including the clinical record: see *Re Stumbillich and Health Disciplines Board* (1984), 12 D.L.R. (4th) 156.

⁹²⁰ *Ontario Mental Incompetency Act*, R.S.O. 1980, c.264, s.1(e).

It is clear that institutionalization is not determinative of the issue of competence.⁹²¹ It is likely that the relevant considerations involve mental capacity, and that physical limitations which may create barriers to an individual's ability to care for himself or herself cannot be used to find a declaration of incompetence.⁹²²

The 1912 case of *Peel v. Peel* is one of few Ontario cases to discuss the actual standards imposed by the *Act*. That case involved a man who was considered by his physicians to suffer from "imbecility". He had very poor eyesight, and received little education. He lived until age forty with his mother until her death. After that time, he lived apparently alone on his farm for eleven years prior to the application for a declaration of incompetence. The court's finding that he was not a "lunatic" within the meaning of the statute is no longer relevant, following the 1937 amendments to the *Act*. Because of the 1937 definition of mental incompetency, however, the court's comments regarding his alleged mental infirmity may be particularly on point:

The test called for by the statute is, whether the person is so weak-minded as not to be able to manage his affairs. The policy of the law is, that the liberty of no man should be interfered with if he has sufficient understanding for the handling of his business according to the ordinary usages of the neighbourhood where he lives.

...

... His answers as a whole are intelligent, some even shrewd and sane; few, rather astray, but this was more from ignorance than from lack of comprehension. ... I am satisfied that he has a modicum of practical sense and judgment sufficient for the handling of his affairs in his own way. His mind has markedly improved since the death of his mother, when he has had to fend for himself, and he will not only be better in mind but will do better in business if left to look after his own little property, uncontrolled by the Court.⁹²³

If these comments are a guide, the standard is one of "the ordinary usages of the neighbourhood". In ascertaining competence, the court considers ability, however, the court also appears to be concerned with the results of the choices.

⁹²¹ *Re Young*, [1942] O.R. 301 (Ont. C.A.).

⁹²² See *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 at 385 (Dist. Ct.), and the cases cited therein. The case involved a twenty-year-old man with cerebral palsy, hydrocephalus, and a developmental disability. Cf. *Re Casford* (1983), 42 Nfld. and P.I.E.R. 240; 127 A.P.R. 240, where the Supreme Court of Prince Edward Island reached a different conclusion in a situation where an individual incapable of caring for herself because of physical limitations but refused to co-operate with persons wishing to institutionalize her. That case was not defended, and it is respectfully suggested that the reasoning of the court is not consistent with the terms of the Prince Edward Island statute.

⁹²³ *Peel v. Peel* (1912), 3 D.L.R. 697 (Ont. H.C.) at 698 f.

The nineteenth century English precedents tended to require a relatively high standard of proof for the superseding of a declaration of incompetence.⁹²⁴ These cases have been modified in Ontario since the case of *Re Annett*, where the court made the following comments about superseding declarations of lunacy:

No one who is sane should be compelled to live, or to die, under the ban of an order declaring him to be insane; there should be no undue delay in "superseding, vacating, and setting aside the order declaring the lunacy;" though, of course, care must be taken that one who has been insane is really sane again — that it is a real case of recovery.

Such cases as *Ex p. Holyland*, 11 Ves 10, and *Re Dyce Sombre*, 1 M & G 116, show the nature of the evidence which in those days was deemed needful to support an application for a superseding of a commission in lunacy; and, although the same question is involved in this less formal application, and the same principles apply to it, it must be borne in mind that important changes, since those cases were dealt with, have taken place in the legal, as well as in the medical, view of lunacy and the diseases which are the cause of it. ... As the *Act* very plainly puts it (sec. 10): "The Court, if satisfied that such person has become of sound mind and capable of managing his own affairs may make an order so declaring;" to be followed, in due course, by an order "superseding, vacating and setting aside the order declaring the lunacy."⁹²⁵

Since that time, it would appear that the standard for superseding a declaration of incompetence is the same as that for the granting of the order.

Since the mid-nineteenth century, applications for a declaration of lunacy have had to be accompanied by affidavits of at least two physicians.⁹²⁶ These affidavits are to include not merely an opinion as to the capacity of the subject, but also the facts upon which that opinion is based, as the actual finding of incompetence has been held to be a matter about which the court must develop its own opinion. In addition, an affidavit from an individual who has known the subject for a period of time is required if possible.⁹²⁷ According to Saskatchewan precedent, the court is also to be informed of the place of residence of the subject, the location of any property of the subject, and the names, places of residence, and occupations of the next of kin of the subject.⁹²⁸

⁹²⁴ See for example *Attorney-General v. Parnther*, 3 Bro. C.C. 441, where the court holds that restoration to a near-perfect state of mind is necessary for an order to be superseded. This standard is softened only somewhat by *Ex Parte Holyland* (1805), 11 Ves. Jr. 10.

⁹²⁵ *Re Annett* (1913), 5 O.W.N. 331 (Common Pleas) at 332 f.

⁹²⁶ This minimum is established by *In Re Patton* (1864), 1 Chy. Chrs. 192, and affirmed in *Re Young*, [1942] O.R. 301 (Ont. C.A.) and *Re Cochran* (1964), 47 W.W.R. 669 (Sask. Q.B.).

⁹²⁷ *Re Young*, [1942] O.R. 301 (Ont. C.A.).

⁹²⁸ *Re Cochran* (1964), 47 W.W.R. 669 (Sask. Q.B.) at 672.

The cases indicate that the courts rely heavily on medical evidence, but do not necessarily accept it uncritically. The case of *Clarke v. Clarke* for example provides the following caution regarding the testing procedure in the preparation of one such opinion:

Now I was not tremendously impressed with the testimony of Dr. McCreary who would appear to have based his opinions largely on the Peabody picture vocabulary test. Considering that a young man had only commenced to communicate at 13 years of age and had lived in the not too stimulating society of seriously retarded patients at Rideau on the multi-phasic unit all his life is it reasonable that he should be exposed to vocabulary tests which distinguish serpent from snake, cascade from waterfall or faucet from tap? It would seem to me as reasonable to test Tarzan's intelligence by tests that were appropriate to the environment of his friend Jane. Nor are tests which depend in a large measure upon muscular dexterity (where one puts blocks in appropriate recesses) appropriate for a person so grossly disabled with cerebral palsy. It seems from the evidence that Dr. McCreary's lengthy examination was a physically painful ordeal for Justin. The whole examination was 3-1/2 hours. He was asked many questions tending to establish that "Justin is not competent in handling money and in related activities and that without care, supervision and control in this regard, his property would be at risk." He is following exactly the language of the Ontario Act. He reports Justin's ability to write and read his own name, to answer questions generally and to remember exactly the date of his last interview some 14 months earlier. Dr. McCreary records a number of spelling failures. I felt his approach to the examination to be tendentious and unsympathetic.⁹²⁹

The *Mental Incompetency Act* provides little guidance as to the procedure to be used in applications under the Act. This has become an issue primarily surrounding the issue of notice. The practice of the Ontario courts has long been to require that notice of the proceedings be served on the allegedly mentally incompetent person. An 1864 case, for example, states:

I should incline also to require that the alleged lunatic be notified, and that access be given to his professional adviser. If a commission sat he would have to be produced: some inmates of the asylum imagine that they are there unjustly; they are probably wrong; but there are many who are competent to instruct counsel as to their cases.⁹³⁰

Nonetheless, the application was eventually granted without service in this case, when officials at the asylum refused to allow service, stating that it would be dangerous to the suicidal patient.

The matter was eventually settled definitively in 1951, when the Supreme Court of Canada held in the case of *Wright v. Wright*⁹³¹ that there was jurisdiction in the court to waive service. In that case there was evidence from two physicians

⁹²⁹ *Clarke v. Clarke* (1982), 40 O.R. (2d) 385 (Dist. Ct.) at 390 f.

⁹³⁰ *In Re Patton* (1864), 1 Chy. Chrs. 192.

⁹³¹ *Wright v. Wright and Guarantee Trust Co.*, [1951] S.C.R. 728.

that service of the application would be harmful to the health of the patient. It has since been held that very clear evidence of such harm is necessary before service will be waived.⁹³² Given that these applications presumably can involve a liberty interest within the meaning of section 7 of the *Charter*, "fundamental justice" is now required in mental incompetency proceedings. *Quaere* on this basis whether suspension of service can be justified today even on the grounds of harm?

The *Act* does provide some unique procedural provisions. The court is permitted to make the declaration upon the written evidence submitted with the application, when convinced beyond a reasonable doubt that the subject of the application is a mentally incompetent person. In the event that the court has a reasonable doubt, a trial of the issue is to be ordered. The allegedly incompetent person is to be produced for examination by the court, and, if requested, by a medical practitioner. It now appears settled that the burden to be applied upon the trial of the issue of incompetence is the civil burden,⁹³³ although there is authority that it is to be a relatively high level of evidence within the civil standard.⁹³⁴

An interesting twist to the *Wright* decision is that it is based on the common law principles relating to the law of lunacy and inquisitions in lunacy, not the civil procedure. In the event of an actual trial of the issue of incompetence, the trial is certainly governed by the usual civil rules,⁹³⁵ as are appeals whether made on the original application without a trial, or at trial.⁹³⁶

The following definition was added to the *Mental Health Act* in 1978:

"mentally competent" means having the ability to understand the subject-matter in respect of which consent is requested and able to appreciate the consequences of giving or withholding consent;⁹³⁷

The test clearly refers to the ability of the patient, although there is a strong feeling that the distinction between actual understanding and the ability to understand

⁹³² *Re Cochran* (1964), 47 W.W.R. 669 (Sask. Q.B.).

⁹³³ *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 (Dist. Ct.) at 384 f.

⁹³⁴ *Re West* (1977), 19 N.B.R. (2d) 387, 30 A.P.R. 387 (N.B.S.C.) at 389.

⁹³⁵ *Mental Incompetency Act*, R.S.O. 1980, c.264, s.8(6).

⁹³⁶ *Mental Incompetency Act*, ss. 7(3) and 8(7).

⁹³⁷ *Ontario Mental Health Act*, R.S.O. 1980, c.262, s.1(g).

one's situation is merely a theoretical point. While it may generally be true that actual understanding is an appropriate guide of the ability to understand, the distinction could still be important, for example, for patients who would be able to understand their situation if sedated somewhat less, or, of course, for those who have not received complete information about their situation.

The test applies to competence in the context of consent to medical treatment, consent to obtain or grant access to the clinical record, and consent to appoint a substitute decision maker. It does not apply to competence to execute a durable power of attorney, or competence to manage the estate. In these areas the common law must be presumed to apply. The phrasing of the test is problematic as regards obtaining access to the clinical record and the appointment of a substitute decision maker, as neither of these areas can really be said to involve "consent".

Consideration of the law regarding treatment in Nova Scotia and of the *Dependent Adults Act* in Alberta informs consideration of the Ontario law, as both these statutes are more highly developed than the corresponding Ontario statutes.

The Nova Scotia statute law provides that all persons admitted to a hospital, psychiatric or otherwise, are to be examined by a psychiatrist within three days of admission to determine whether the patient is capable of consenting to treatment.⁹³⁸ Section 47 of the *Act* states that persons are to be presumed capable of consenting to treatment if the examination is not carried out in the required period of time. On the theory that provisions of statutes are to be read correctively, this may mean that there is no presumption of competence pending the examination. The framework of criteria to be used in this context is as follows:

In determining whether or not a person is capable of consenting to treatment, the examining psychiatrist shall consider whether or not the person being examined

- a) understands the condition for which the treatment is proposed;
- b) understands the nature and purpose of the treatment;
- c) understands the risks involved in undergoing the treatment; and

⁹³⁸ Nova Scotia *Public Hospitals Act*, R.S.N.S. 1967, c.249, s.43 as amended. Consolidated as c. H-19, s.43. Re-evaluations are to occur at least every three months for the first year of admission, and at least annually thereafter.

- d) whether or not his ability to consent is affected by his condition.⁹³⁹

Insofar as the distinction is relevant, the Nova Scotia *Act* considers the actual understanding of the individual, not the ability of the individual to understand. In the event that the individual is not capable of consent, the individual's spouse, next of kin, or, if none, the Public Trustee may consent on the individual's behalf.⁹⁴⁰

The Nova Scotia *Medical Consent Act* requires that an individual be capable of giving consent to medical treatment in order to appoint a substitute decision maker under the *Act*.⁹⁴¹ Elsewhere, the *Act* elsewhere refers to the provisions of the *Hospitals Act*, and consequently the definition of competence contained in the *Hospitals Act* presumably also regulates capacity in the appointment of substitutes.

The Nova Scotia *Hospitals Act* is not remarkable for the procedures it establishes for the determination of competence to manage one's estate. It does provide the following definition of competence in this context, a definition which is somewhat more extensive than usual in Canadian statutes:

In determining whether or not a person is competent to administer his estate, the psychiatrist examining the person shall consider:

- a) the nature and degree of the person's condition;
- b) the complexity of the estate;
- c) the effect of the condition of the person upon his conduct in administering his estate; and
- d) any other circumstances the psychiatrist considers relevant to the estate and the person and his condition.⁹⁴²

⁹³⁹ Ibid at s.44(2). The criteria contained in the Manitoba *Mental Health Act*, R.S.M. 1987, c. M110, s.24(3) as amended by R.S.M. 1987 Supp., c.23, s.7 are almost identical to the Nova Scotia criteria.

⁹⁴⁰ Nova Scotia, *Public Hospitals Act*, s.46; also Manitoba *Mental Health Act* s.24(5.1).

⁹⁴¹ Nova Scotia *Medical Consent Act*, S.N.S. 1988, c.14, s.2.

⁹⁴² Nova Scotia *Public Hospitals Act*, s.44(3).

The Alberta *Dependent Adults Act*⁹⁴³ is examined as it is the only significant legislative revision to a general statute regarding mental competence and guardianship since the 1930s, and the only clear departure from nineteenth century principles in this body of Canadian statute law.

Largely as a result of the nineteenth century debate, Canadian guardianship statutes are generally fairly clear about what powers a committee of the estate actually possess. These statutes offer almost no guidance, however, as to the powers of a committee of the person. The Alberta statute is an exception, in that it actually defines concrete powers and areas of decision making authority to the guardian:

- a) to decide where the dependent adult is to live, whether permanently or temporarily;
- b) to decide with whom the dependent adult is to live and with whom the dependent adult is to consort;
- c) to decide whether the dependent adult should engage in social activities and, if so, the nature and extent thereof and related matters;
- d) to decide whether the dependent adult should work and, if so, the nature or type of work, for whom he is to work and related matters;
- e) to decide whether the dependent adult should participate in any educational, vocational or other training and, if so, the nature and extent thereof and related matters;
- f) to decide whether the dependent adult should apply for any licence, permit, approval or other consent or authorization required by law;
- g) to commence, compromise or settle any legal proceeding that does not relate to the estate of the dependent adult and to compromise or settle any proceeding taken against the dependent adult that does not relate to his estate;
- h) to consent to any health care that is in the best interests of the dependent adult;
- i) to make normal day to day decisions on behalf of the dependent adult including the diet and dress of the dependent adult;
- j) any other matters specified by the Court and required by the guardian to protect the best interests of the dependent adult.⁹⁴⁴

⁹⁴³ S.A. 1976, c.63. The *Act* received minor modifications later in the 1970's, prior to its consolidation as R.S.A. 1980, c. D-32. There have been two more significant revisions to the *Act* since that time: *Dependent Adults Amendment Act*, S.A. 1980, c.15; and *Dependent Adults Amendment Act, 1985*, S.A. 1985, c.21. These amendments have not altered the essential thrust of the *Act*, but have altered some standards regarding implementation.

⁹⁴⁴ s.10(2), as amended by S.A. 1985, c.21, s.11(1). Apart from the addition of clause (j), the areas listed are essentially similar to those listed in C.S.A. 1980, c. D-32, ss. 9(1) and 10(2).

In provinces such as Ontario where the relevant legislation does not establish specific powers of the personal guardian, the guardian receives such powers as may be granted by the court. The court is the inheritor of the Royal Prerogative power, which would include the items in the above list.⁹⁴⁵ Therefore, absent statutory direction to the contrary, all of these powers could be granted to the committee of the person in Ontario.

In this regard, a few statutory provisions of Ontario legislation are relevant, for example, the provisions of the *Mental Health Act* regarding competence apply notwithstanding the appointment of a committee of the person pursuant to the *Mental Incompetency Act*.⁹⁴⁶

The Alberta statute was intended to introduce a flexible approach to guardianship. Partial guardianship was specifically included in the statute, and a guardian's authority could be limited to any combination of the powers in the above list.

Partial guardianship is a novel concept in Canada, introduced by the Alberta statute and not available under Ontario law.⁹⁴⁷ As has been pointed out, the custody of "lunatics" and "natural fools" is with the Crown. For this jurisdiction to be invoked, however, there must be a finding of incompetence. Once the finding is made, jurisdiction over the individual vests entirely in the Crown, except as modified by statute. The only modification which is relevant is the power of the court to limit a finding of incompetence to personal or estate matters.⁹⁴⁸

⁹⁴⁵ The jurisdiction over the person is theoretically unlimited, although it must be exercised according consistent with the principles developed by common law, i.e., in the best interests of the ward: see *Re Eve* (1986), 13 C.P.C. (2d) 6 at 24 ff.

⁹⁴⁶ *Mental Health Act*, s.1a, gives the committee of the person authority to act only when the patient is not mentally competent, which is in turn defined in the *Act*. Cf. *Mental Health Act*, s.36(9), which limits the effect of the estates provisions of the *Act* to persons without committees of the estate under the *Mental Incompetency Act*.

⁹⁴⁷ See comments in *Clarke v. Clarke* (1982), 40 O.R. (2d) 383 at 384 (Dist. Ct.), where the court states that limited guardianship is not available in Ontario.

⁹⁴⁸ *Mental Incompetency Act*, R.S.O. 1980, c.264, ss. 8(5), 12(1)(a).

This is not to say, of course, that the court cannot limit the authority of a committee of the person or estate. The authority of committees is granted by the court, and they are "bailees" or "statutory agents" of the court.⁹⁴⁹ It has been held that the committee can do nothing without the sanction of the court.⁹⁵⁰ The ability to limit the authority of the committee must consequently be implied. In fact, in some Canadian jurisdictions, limited committeeships would appear to be common.⁹⁵¹ This is not a partial committeeship, however, as the individual does not maintain decision making authority for the matters over which the committee is precluded from acting. Instead, the court exercises the power of decision making in these areas, and an application to the court is required.

The following clause of the 1976 *Act* provided the test to be met before the appointment of a guardian:

- 6(1) When the Court is satisfied that a person named in an application for an order appointing a guardian is
- a) an adult,
 - b) unable
 - i) to care for himself, and
 - ii) to make reasonable judgments in respect of all or any of the matters relating to his person,
- and
- c) is need of a guardian,
- the Court may make an order appointing a plenary guardian or a partial guardian.
- (2) The court shall not make an order under subsection (1) unless it is satisfied that the order would be in the best interests of the person in respect of whom the application is made.

⁹⁴⁹ See *Re Avery*, [1952] O.W.N. 689, *Re Eve* (1986), 13 C.P.C. (2d) 6.

⁹⁵⁰ *Re Breen*; *Breen v. Toronto General Trusts Corp.* (1909), 18 O.L.R. 447 (C.A.).

⁹⁵¹ See, for example, *Re Cochran* (1964), 47 W.W.R. 669 (Sask. Q.B.), where the court suggests that the power to dispose of real estate on behalf of the incompetent person should not normally be granted to a committee of the estate.

- (3) The court shall not make an order appointing a plenary guardian unless it is satisfied that a partial guardianship order would be insufficient to meet the needs of the person in respect of whom the application is made.

Unlike the statutes in effect in other Canadian jurisdictions, which date from decades before the Alberta statute, the *Alberta Act* can be seen as incorporating concern that the intrusion into an individual's life be the minimum consistent with the state's *parens patriae* role. Whereas the standards of the earlier statutes, including the Ontario statute, reflect only concern for the protection of the subject of the application, the Alberta statute reflects the more modern attitude that the dignity and autonomy of the subject is also a value worthy of protection.

Recent amendments to section 6 have preserved and perhaps fortified the protection of the interest in individual autonomy. Now, it is required prior to the appointment of a guardian that the individual be **repeatedly and continuously** unable to care for himself or herself and to make reasonable judgments on matters related to his or her person, and it must further be demonstrated that the appointment of a guardian would result in substantial benefit to the person.⁹⁵²

⁹⁵² In the result, the revised section reads as follows:

6(1) When the Court is satisfied that a person named in an application for an order appointing a guardian is

- a) an adult, and
- b) repeatedly or continuously unable
 - i) to care for himself, and
 - ii) to make reasonable judgments in respect of matters relating to his person

the Court may make an order appointing a guardian.

(2) The Court shall not make an order under subsection (1) unless it is satisfied that the order would

- a) be in the interests of, and
- b) result in substantial benefit to

the person in respect of whom the application is made.

Section 6(3) of the 1976 *Act* was revoked, but its effect was re-introduced as section 10(1).

These principles may be seen to some degree in the common law surrounding the appointment of committees in Ontario. Notwithstanding the obligatory wording of section 12 of the *Mental Incompetency Act*,⁹⁵³ there is authority that the court will not appoint a committee unless it is demonstrated that the intervention would be of benefit to the incompetent person.⁹⁵⁴ This was relied on in the 1892 case of *Re Clark*.⁹⁵⁵ The court held that the incompetency proceedings were collateral to the real issue, which involved the validity of a deed and was being litigated separately. The lunatic was being well cared for by one of his children. The order was therefore denied on the basis that it would serve no useful purpose. Under the present Ontario statute, the court in *Re Ridler* indicated that the size of an estate was a relevant consideration in determining whether a committee ought to be appointed.⁹⁵⁶

The following clauses of the *Alberta Act*, introduced in 1980, are not consistent with the civil libertarian approach found elsewhere in the *Alberta statutes*:

20.1(1) Where an adult person

- a) is, in the written opinion of 2 physicians, in need of an examination or medical, surgical or obstetrical treatment or is, in the written opinion of 2 dentists, in need of dental treatment,
- b) is incapable by reason of mental or physical disability of understanding and consenting to the examination or medical, surgical, obstetrical or dental treatment needed, and
- c) has not previously withheld consent to the examination or medical, surgical, obstetrical or dental treatment needed, to the knowledge of either of the physicians or the dentists referred to in clause (a),

a physician or dentist may, without the consent of any person, examine the person, prescribe treatment for the person and provide the person with the medical, surgical or obstetrical treatment or with the dental treatment, as the case may be, in the manner and to the extent that is reasonably necessary and in the best interests of the person examined or treated, in the same way that the physician or dentist could have acted if the person had been an adult of full legal capacity who consented to the examination or treatment.⁹⁵⁷

⁹⁵³ "Where an order has been made declaring a person a mentally incompetent person ... the court ... shall ... appoint a committee ...": s.12(1).

⁹⁵⁴ See, for example, *Re Young*, [1942] O.R. 301 (Ont. C.A.).

⁹⁵⁵ *Re Clark* (1892), 14 P.R. 370.

⁹⁵⁶ *Re Ridler* (1930), 65 O.L.R. 559 (C.A.). The statement is made somewhat offhandedly at 562.

⁹⁵⁷ Introduced into the *Act* by R.S.A. 1980, c.6(Supp.), s.16.

No specific due process safeguards are included regarding this section, although section 20.1(2) provides that the section does not apply when a guardian with authority to consent to treatment has been appointed. The failure to provide due process protections suggests a possible violation of section 7 of the *Charter of Rights*, which guarantees the right to security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

While the Alberta statute provides a new approach to problems of guardianship, it is not clear how far it advances an understanding of competence. There is no useful explanation of what standards are to be applied by physicians in their assessment of a patient under clause 20.1(1)(b), although the phrasing of the section would suggest a functional test of ability, rather than a result-oriented test as to whether the patient consents to the treatment or not. The requirement in the general test of need for guardianship, that the individual be unable to make "reasonable judgments" in respect of his person,⁹⁵⁸ suggests a test in which the choices actually made by an individual are at least a relevant factor for the consideration of the court. No assistance is provided by the statute, however, as to how one is to evaluate "reasonableness".

⁹⁵⁸ s.6(1)(b)(ii). The comparable test, the inability to make reasonable judgments in respect of matters relating to all or any part of his estate, is the test for appointment of a trustee under section 25(1) of the *Act*.

VI. FITNESS TO STAND TRIAL: COMPETENCE IN THE CRIMINAL LAW

The primary situation in which competence becomes an issue in the criminal law is the determination of an accused's fitness to stand trial. The context of criminal law differs in a number of ways from civil law, limiting the relevance of fitness determinations; however, a number of points warrant consideration. The tradition that the criminal law involves the imposition of particularly intrusive measures upon the subject makes it particularly distasteful to convict an unfit individual. It is also considered of central importance that an individual be able to make full answer and defence to the charges they are facing, a right which is placed in jeopardy if the accused is of doubtful competence.

On the other hand, there is no provision in criminal law for the appointment of a litigation guardian, as in civil law. There is a social interest that a criminal matter be concluded, and this interest may well be consistent with the interest of the accused, if there is a valid defence. The result of a finding of unfitness is detention, under a warrant of the Lieutenant Governor, which may result in incarceration for a significantly longer period than under a conviction. There is thus a countervailing pressure to limit findings of unfitness.

For centuries, the law has required a certain standard of mental health before an individual may be convicted of a criminal offence. In the seventeenth century, for example, Sir Matthew Hale wrote:

If a man in his sound memory commits a capital offence, and before his arraignment becomes absolutely mad, he ought not by law to be arraigned during such his frenzy, but be remitted to prison until that incapacity be removed; the reason is, because he cannot advisedly plead to the indictment. ... If such person after his plea, and before his trial, become of none sane memory, he shall not be tried.⁹⁰⁹

This common law rule was codified in 1800 by the *Criminal Lunatics Act* in the following terms:

If any person indicted for any offence shall be insane, and shall upon arraignment be found so to be by a jury lawfully empanelled for that purpose, so that such person cannot be tried upon such indictment ... it shall be lawful for the court ... to direct such finding to be recorded, and thereupon to order such person to be kept in strict custody until His Majesty's pleasure shall be known.⁹¹⁰

⁹⁰⁹ M. Hale *The History of the Pleas of the Crown* (1680), pp. 35 f.; quoted *R. v. Podola*, [1960] 1 Q.B. 324 at 352. Recall that in this period, all major offences were capital offences.

⁹¹⁰ *Criminal Lunatics Act*, 39/40 George III (1800) c.94, s.2.

While the law regarding confinement of criminal lunatics and the establishment and governance of asylums for criminal lunatics underwent significant amendment in the nineteenth century, this provision has remained essentially unchanged in England.

This is a different issue entirely from the defense of insanity. The insanity defense concerns the understanding of the accused at the time the crime was committed regarding his or her actions. In one classic test, did the accused understand when committing the crime that his or her actions were wrong? At issue in a fitness determination is the abilities of the accused on the day of trial: can he or she conduct a defense.

The classic judicial remarks regarding the 1800 statute are contained in the 1836 case of *R. v. Pritchard*. This case actually involved an accused who was unable to speak or hear. As in early civil law, such persons were subjected to the same tests regarding competence as the mad. Baron Alderson made the following remarks to the jury selected to try the issue:

There are three points to be inquired into: — First, whether the prisoner is mute of malice or not; secondly, whether he can plead to the indictment or not; thirdly, whether he is of sufficient intellect to comprehend the course of proceedings on the trial, so as to make a proper defence — to know that he might challenge any of you to whom he may object — and to comprehend the details of the evidence, which in a case of this nature must constitute a minute investigation. Upon this issue, therefore, if you think that there is no certain mode of communicating the details of the trial to the prisoner, so that he can clearly understand them, and be able properly to make his defence to the charge; you ought to find that he is not of sane mind. It is not enough, that he may have a general capacity of communicating on ordinary matters.⁹⁶¹

The English authorities have departed little from that phrasing of the test. The factors to be considered in the determination as enumerated in the following passage from a 1977 case can be perceived as mere extensions of the 1836 criteria:

Nowhere does the learned judge deal with the matters upon which the jury have to base their findings: the ability of the defendant to challenge jurors, the ability of the defendant to instruct counsel, the ability of the defendant to understand the evidence and the ability of the defendant to give evidence himself.⁹⁶²

The onus to prove unfitness is on the party raising it.⁹⁶³ There appears to be dispute as to the applicable standard. The English Court of Appeal appeared to

⁹⁶¹ *R. v. Pritchard* (1836), 7 Car. & P. 304 f.

⁹⁶² *R. v. Berry* (1977), 66 Cr. App. R. 156 (C.A.).

⁹⁶³ *R. v. Podolski*, [1960] 1 Q.B. 324 at 350.

hold in 1960 that the burden was the balance of probabilities.⁹⁶⁴ This finding occurred in a case where the issue of fitness was raised by the defence. In 1968, the same court acknowledged conflicting decisions, but held, in a case where the Crown raised the fitness issue, the burden was beyond reasonable doubt.⁹⁶⁵ This is presumably to be taken as overruling, to the extent of any inconsistency, the 1960 decision, which does not appear in its reasoning to limit itself to cases where the issue is raised by the defence.

The 1960 case of *R. v. Podola*⁹⁶⁶ is interesting in the context of the legal history of insanity. That case involved an individual who allegedly had no recollection of any of the events in the period prior to his arrest, including the period during which he was alleged to have murdered someone. It was alleged by the defence that he was unfit to stand trial, as he would be unable to testify in his defence and would be unable to alert his lawyer to possible defences such as provocation. The court considered the comments of Sir Matthew Hale, quoted above, and made the following comments regarding Hale's discussion of memory:

Mr. Lawton [defence counsel] urged that these expressions must apply where all memory of the events surrounding the alleged crime has disappeared owing to hysterical amnesia. It is to be observed, however, the above passages occur in Chapter IV where Sir Matthew Hale is considering "the defect of idiocy, madness and "lunacy" in reference to criminal offenses. It will also be seen that in the first passage quoted, "sound memory" is contrasted with "absolutely mad" and with "frenzy." Accordingly, in our judgment, the word "memory" there used does not relate to recollection but to a state of mind.⁹⁶⁷

This is a somewhat startling statement. The phrase used by Sir Matthew, "non sane memory", is essentially similar to the phrase which is the standard test for competency to make a will, yet several centuries of jurisprudence prior to *Podola* understood "memory" in the wills context to mean recollection, and had developed standards as to the level of recollection which was required.⁹⁶⁸ Further, the court does not particularly indicate what state of mind Sir Matthew would have been referring to. It is tempting to suggest that the court in this case was motivated at least in part by a concern that an accused might feign amnesia, and thus avoid trial.

⁹⁶⁴ See *R. v. Podola*, above.

⁹⁶⁵ *R. v. Robertson* (1968), 52 Crim. App. R. 690 at 695.

⁹⁶⁶ [1960] 1 Q.B. 324 (C.A.).

⁹⁶⁷ at 352.

⁹⁶⁸ See for example *The Marquess of Winchester's Case* (1598), 6 Co. Rep. 23a; *Marsh v. Tyrell and Harding* (1828), 2 Hagg. Ecc. 84; *Harwood v. Baker* (1840), 3 Moore 282, esp. at 290 f.; *Banks v. Goodfellow* (1870), 5 Q.B. 549.

The court continues by making an extraordinarily ambiguous statement about the effect on the burden of proof in cases where the accused does not remember the events forming the basis of the charge. First, the court quotes the following passage from the Scots case of *Russell v. H.M. Advocate*:

The conclusions which I feel bound to draw are that loss of memory may be an important element leading to conclusion that a panel is insane. ... But if it falls short of that, loss of memory in a person otherwise normal and sane plays its full part, if it is sufficiently proved, in increasing the onus on the Crown, and in raising doubts to which it may be the duty of the jury to give effect in a verdict of acquittal after investigation of the whole case. But as our law stands, it can have no further or other effect.⁹⁶⁹

The English Court of Appeal continues as follows:

As we understand it, the words "in increasing the onus on the Crown" do not mean that strictly the onus is any greater, but that a judge should point out to a jury that they must take into consideration carefully the fact that the accused cannot remember the events.⁹⁷⁰

The result is not at all clear. On the one hand, given that the burden on the Crown in a criminal case is proof beyond a reasonable doubt, in any event, it is not clear what higher standard the Scots' court might wish to impose. On the other hand, the English case offers no guidance as to what the jury is to make of the fact that the accused remembers nothing of the events surrounding the alleged offence, other than it does not mean that they have to be more convinced of the Crown's case.

American case law is largely similar in structure to the British. The most recent authoritative test, essentially similar to the English test, is established by the American Supreme Court in *Dusky v. United States*:

We also agree with the suggestion of the Solicitor General that ... the test must be whether he [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding -- and whether he has a rational as well as a factual understanding of the proceedings against him.⁹⁷¹

⁹⁶⁹ *Russell v. H.M. Advocate* [1946] S.C. (1.) 37 at 48; quoted in *Podolski* at [1960] 1 Q.B. 355 f. Ellipses inserted in *Podolski*.

⁹⁷⁰ *Podolski* at 356.

⁹⁷¹ *Dusky v. United States*, 362 U.S. 402 at 402 (1960).

The case law provides few useful interpretations of this test. The ability to testify is given great weight.⁹⁷² A recent Pennsylvania case has referred to "the ability to comprehend his position as one accused of a crime and to cooperate with his counsel in making a rational defense".⁹⁷³ It is unclear how this clarifies things. American case law is more succinct about what does not constitute a lack of fitness to stand trial. As with the English case law, a diagnosis of insanity is not sufficient of itself.⁹⁷⁴ Erratic or uncontrolled behaviour in court is not in itself a determining factor, as such behaviour can be controlled.⁹⁷⁵ The fact that the stress of a trial may not be in the medical best interests of an accused is not a basis for a finding of unfitness.⁹⁷⁶

The case of *United States v. Sermon*⁹⁷⁷ warrants consideration as a parallel to the *Podola* case. The accused in *Sermon* had organic brain syndrome, which affected his memory. While he did not have a total memory loss, his memory was at best incomplete. The standard of fitness as regards assisting one's counsel was explained by the court as follows:

Defendants do not assist in their own defense by telling their lawyers what motions to file or how a particular witness should be examined, or cross-examined. ... 'to assist in his defense' of course does not refer to legal questions involved but to such phases of a defense as a defendant usually assists in, such as accounts of the facts, names of witnesses, etc. We think it must also be added that the primary assistance that must be rendered counsel is a full revelation of the facts within the knowledge of the defendant in areas which are in legitimate dispute.⁹⁷⁸

The court goes on to hold that relevant factual material had already been made available to the lawyer by the accused, and, rather illogically, that there was no

⁹⁷² *United States v. Adams*, 297 F. Supp. 596 (N. Y., 1969), *United States v. Sermon*, 228 F. Supp. 972 (Miss., 1964).

⁹⁷³ *Commonwealth v. Wimer*, 550 A. 2d 241 (Pa. Super., 1988); see also *People v. Pennington*, 426 P. 2d 942 (Cal., 1967) at 947.

⁹⁷⁴ *Feguer v. United States*, 302 F. 2d 214 (8th Cir., 1962) at 236; *United States v. Adams*, 297 F. Supp. 596 (N.Y., 1969).

⁹⁷⁵ *United States v. Adams*, 297 F. Supp. 596 (N.Y., 1969).

⁹⁷⁶ *Commonwealth v. Wimer*, 550 A. 2d 241 (Pa. Super., 1988).

⁹⁷⁷ 228 F. Supp. 972 (1964).

⁹⁷⁸ at 978.

evidence of further material that the accused would remember if of sound mind which would be relevant.⁹⁷⁹ This obviously begs the question.

The American law is clear that once there is a reasonable concern of the court as to the fitness of the accused, the judge is to be satisfied that the accused is fit before proceeding with the trial.⁹⁸⁰ The onus is on the party alleging unfitness, and proof is to be clear and convincing.⁹⁸¹ The determination of fitness is a judicial decision, and while the court may of course consider medical evidence, it must reach its own conclusion.⁹⁸² Notwithstanding this rule, it is common for the only evidence called in a fitness determination in the United States to be that of medical professionals.

The case of *State of Tennessee v. Benton*⁹⁸³ provides some indication of the evidence normally called on a fitness hearing. The case involved a charge of multiple rape by a man functioning at the approximate level of a five-year-old child. A licensed psychological examiner testified. She had interviewed the accused, with a view to finding whether he understood why he had been charged. She administered various psychological tests, and scored the accused on both the Weschler Adult Intelligence Scale and the Vineland Adaptive Behaviour Scale.⁹⁸⁴ Two other witnesses were respectively a psychiatric social worker and a psychiatrist. They testified on the basis of interviews with the accused. These interviews included consideration of the accused's understanding and recollection of his childhood, his adult development, his social circumstances, and his environment. In this case, there was also independent evidence regarding the functioning of the accused in the community. The psychological testing and mental status examinations present in this case would appear to be typical of other American cases. Some other cases also have neurological tests, such as EEGs.

⁹⁷⁹ at 980.

⁹⁸⁰ See, for example, *Drope v. Missouri*, 420 U.S. 162 (1975).

⁹⁸¹ *Commonwealth v. Wimer*, 550 A. 2d 241 (Pa. Super., 1988).

⁹⁸² See, for example, *Commonwealth v. Wimer*, 550 A. 2d 241 (Pa. Super., 1988); *United States v. Sermon*, 228 F. Supp. 972 (1964).

⁹⁸³ *State of Tennessee v. Benton* 759 S.W. 2d 427 (Tenn. Cr. App., 1988).

⁹⁸⁴ American case law is mixed as to the constitutional validity of the use of such psychological tests. There is authority that, when such tests are demonstrably not racially neutral, the use of such tests for streaming school children is unconstitutional: see *Larry v. Riles*, 495 F. Supp. 926 (N.D. Cal., 1979). There is also authority that when such tests are used in conjunction with other non-biased tests, the process may not be discriminatory: see *PASE v. Hammon*, 506 F. Supp. 831 (N.D. Ill., 1980).

The Canadian law regarding fitness to stand trial is governed by the provisions of the *Criminal Code*.⁹⁸⁵ The provisions are in two stages. Firstly, to trigger an inquiry, the presiding judge must decide that there is "sufficient reason to doubt that the accused is, on account of insanity, capable of conducting his defence."⁹⁸⁶ The case of *R. v. McLeod, Pinnock and Farquharson*⁹⁸⁷ provides an example of the parameters of this first stage. The issue arose in a case of constructive murder. The issue was raised by counsel for the defendant, who called a psychiatrist and a psychologist as witnesses. The trial judge found their evidence ambiguous, and sent the accused for a full assessment in a local forensic unit, where the accused was examined by another psychiatrist, psychologist, a psychiatric nurse, a social worker and a correctional officer. The psychiatrist and the psychologist testified that, while the accused was illiterate and in the dull normal range of intelligence, he was not suffering from any major mental illness and was fit to stand trial. The trial judge found that there was insufficient evidence to require the second stage of the inquiry, and the issue of fitness was therefore not put to the jury.

The Court of Appeal held that the actions of the judge were appropriate. While it was not open to the judge to determine any conflicts of testimony, the decision to send the matter on to the second stage was discretionary. Notwithstanding that the judge in his reasons did openly determine conflicts of testimony, the Court of Appeal did not interfere in the decision not to proceed to the second stage of the analysis.

If the judge is satisfied that there is sufficient reason to doubt that the accused is capable of conducting a defense, the second stage occurs. This is the actual inquiry. The best view of the law in Canada at this time is that this second stage is inquisitorial, rather than adversarial in nature. The leading case is *R. v. Budic*, from the Alberta Court of Appeal in 1977:

In this view, that the trial of the issue is not to be taken on an adversary basis, no burden of proof in the accepted sense rests on any person involved in the issue, but there is a responsibility on all concerned to contribute to the hearing so far as they are able, in order that a proper verdict may be reached having in mind the purpose for which the issue is directed. ... The evidence in the issue, and its effect, must be weighed on the balance of that purpose. One aspect is the ability to instruct counsel

⁹⁸⁵ R.S.C. 1985, c. C-42.

⁹⁸⁶ *Criminal Code*, R.S.C. 1985, c. C-42, s.615(1).

⁹⁸⁷ *R. v. McLeod, Pinnock and Farquharson* (1983), 6 C.C.C. (3d) 29 (Ont. C.A.).

charged, and the position taken by defence counsel must be given fair consideration since he in particular will necessarily have to come to some conclusion as to whether the instructions he was able to receive were adequate or inadequate to enable him to conduct the defence intended to be put forward, or, as in this case, has been put forward. ... Another aspect is the medical testimony when it is properly directed to the issue of fitness as distinct from defence evidence under s.16. We are dealing here with the question of a mental status or condition, and I think that the Court trying the issue must be reasonably well satisfied that the condition of unfitness exists before coming to a verdict that it does. ... I do not apply here the presumption of sanity under s.16 for the purposes of the prosecution of the charge. The question under consideration is at large, to be determined in the interests of fairness to the accused, and which ought to include the undesirability of having postponed indefinitely a verdict on the crime with which he is charged.⁹⁸⁸

On this analysis, there is no explicit onus of proof. Query whether this case overrules prior case law which holds that when an accused has been found unfit, the onus is on the Crown in a subsequent inquiry to demonstrate on a balance of probabilities that the accused has become fit?⁹⁸⁹

The Canadian statute explicitly requires the report of a "duly qualified medical practitioner" except in cases where this would be impractical, and it is not particularly rare that medical evidence will be the only evidence tendered on the issue of fitness. This does not in theory mean, however, that the determination is a strictly medical matter. The Alberta Court of Appeal in a judgement related to the *Budic* decision recently re-affirmed that the decision as to fitness is to be made by the trier of fact, and medical opinion, while relevant, is not necessarily to be determinative. The unfitness of the accused to stand trial is not to become synonymous with a diagnosis of insanity.⁹⁹⁰

A standard statement of the test of fitness is contained in *R. v. Wolucky*, a 1952 decision of the Saskatchewan Court of Appeal:

The insanity contemplated by s.967 of the Criminal Code [now section 615] is different from that set forth in s.19 [now section 16] as sufficient to support the defence of insanity; the test on the issue is whether or not the accused is able to understand the proceedings; to try him if he is not able to understand the proceedings and to instruct his counsel would deprive him in all probability of his right to make his full defence. No one can be rightly tried while insane.⁹⁹¹

⁹⁸⁸ *R. v. Budic* (1977), 35 C.C.C. (3d) 272 (A.C.A.) at 278. See also *R. v. Roberts* (1975), 24 C.C.C. (2d) 539 (B.C.C.A.) at 546.

⁹⁸⁹ See *R. v. Roberts* (1975), 24 C.C.C. (2d) 539 (B.C.C.A.) at 548 f.

⁹⁹⁰ See *R. v. Morris* (1977), 35 C.C.C. (2d) 157 (Alta. C.A.).

⁹⁹¹ *R. v. Wolucky* (1952), 103 C.C.C. 43 (Sask. C.A.) at 46 f. The reference to section 19 refers to insanity as a substantive defence.

This is essentially similar to the English and American tests.

Three cases provide some indication of the application of the test. The Canadian parallel to *Podola* and *Sermon* is *R. v. Boylen*.⁹⁹² In that case, as in its foreign counterparts, the accused was unable to remember the events which formed the basis of a charge of criminal negligence causing death. The Nova Scotia court, like the English and American courts, did not allow the lack of memory to preclude a finding of fitness. The Nova Scotia court found that the rule about fitness is essentially procedural in nature. Therefore the issue becomes the ability of the accused to understand the procedure of the courts to a degree that he can advise counsel.⁹⁹³ This approach deftly avoids the issue of the right of the accused to testify in his own defense. The issue becomes whether the accused is mentally capable of answering questions, rather than whether the accused remembers anything of relevance in his or her own defence. While this approach may be clearer than the reasoning in the American and English cases, it is no more satisfactory.

The law relating to delusional individuals and fitness bears some relation to the civil law on the point, in that it is clear that a delusion does not *per se* imply a finding of unfitness. There is case law to support an interpretation very similar to the civil test of incompetence where the delusions affect the decisions to be made. The case of *R. v. Woltucky*,⁹⁹⁴ for example, involved an accused who believed that the police had a machine which read the thoughts of the accused. In that case, it was held that this delusional belief would have a sufficient effect upon the understanding of the accused of the proceedings and the accused ought to be found unfit.

Other authority would weigh the delusion with other factors to be raised in the trial, in reaching a result. The following passage from the Alberta Court of Appeal is illustrative:

When counsel puts forward insanity as the defence to the charge, the accused has a right to have that defence tried and it should not be lightly denied to him. The persistence of a delusion to the time of trial is not unusual. Its effect as a defence does not have a necessary relation to the fitness of the accused to stand his trial. The latter issue must be determined on the totality of the evidence adduced and directed to that end on the trial of the issue. The ability to distinguish between right and wrong may be the very defence to the charge which counsel seeks to put forward, and one would expect that

⁹⁹² *R. v. Boylen* (1972), 18 C.R.N.S. 273 (N.S. Mag. Ct.).

⁹⁹³ at 276.

⁹⁹⁴ *R. v. Woltucky* (1952), 103 C.C.C. 43 (Sask. C.A.).

it was through his interviews with the accused that he got sufficient instruction for his needs in preparing the defence. Fitness to stand trial involves other considerations.⁹⁹⁵

That case, in fact, involved a delusion related to the actual facts of the case, however the competing interests identified by the case are of broader application.

The case of Reference *Re Regina v. Gorecki (No. 1)* is interesting because it concerns an individual who denied his illness. The case was one of murder, and the bulk of the medical testimony was that the accused, while capable of following the proceedings, was mentally ill. It was agreed among the bulk of the medical experts that the illness in question was an affective disorder, which resulted in the refusal of the accused to consider any defense related to insanity. These doctors were of the opinion that the accused was unfit to stand trial. The Ontario Court of Appeal disagreed:

In the present case, the learned experts who expressed opinions that Dr. Gorecki was unfit to stand trial did not challenge his ability to follow the proceedings but simply relied on his inability to accept the possibility that he could have been wrong or insane at the time of the shooting. In our respectful view, these doctors were not applying the proper test of fitness to stand trial.⁹⁹⁶

The court agrees explicitly with the English Court of Appeal that the ability to act in one's own best interest is not the appropriate test of fitness.⁹⁹⁷

The criminal fitness cases provide a comparison point with the civil competence cases. Like their civil counterparts, they are tests based on ability. It is perhaps arguable that the concern with ability is narrower in the criminal context than the civil. The tests would appear to be narrowly centred on the ability to process the matters at hand, rather than the ability to place one's life or choices in perspective. While it is admittedly not explicitly the test of competence, it is difficult to imagine a civil court, for example, holding that the ability to act in one's best interest was somehow not the issue in a competence determination, as the criminal courts have held in cases such as *Gorecki*. That is not to say that actually acting in one's best interest is the test of civil competence; it is rather to say that the civil standards have tended to be concerned that delusions, for example, not preclude the individual from choosing whether or not to act in their best interest. Memory, found largely irrelevant in the criminal fitness context, has been very important in determining civil competence. As we have seen, evidence of an

⁹⁹⁵ *R. v. Budic* (1977), 35 C.C.C. (2d) 272 (Alta. C.A.) at 279.

⁹⁹⁶ *Reference Re Regina v. Gorecki (No. 1)* (1976), 32 C.C.C. (2d) 129 (Ont. C.A.) at 134. *Emphasis in original.*

⁹⁹⁷ *Ibid* at 133 f. The Court relies on the English case of *R. v. Robertson* (1968), 52 Cr. App. R. 690.

individual's ability to function in the community at the time of the hearing and in the past is frequently introduced in civil competency hearings and may indeed be required in proceedings under the *Mental Incompetency Act*. It is not normally introduced in a fitness hearing. Where the civil determination of competence, by comparison, may be seen as a broad consideration of the abilities of the individual, the criminal fitness hearing is a narrower determination, limited to very specific issues.

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An Act respecting Lunatics (Ontario), 50 Victoria (1887) c.54

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